Filing at a Glance

Company:	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates
State:	Colorado
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health - Dental
Filing Type:	Rate
Date Submitted:	06/14/2013
SERFF Tr Num:	ANTV-129075587
SERFF Status:	Closed-Filed
State Tr Num:	278985
State Status:	Filed
Co Tr Num:	
Implementation Date Requested:	01/01/2014
Author(s):	Gene Garcia, Brenda Davis, Eileen Quinlan, Judy Hamm
Reviewer(s):	Nichole Boggess (primary), Cathy Gilliland, Michael Muldoon, Amy Filler, Rachel Plummer
Disposition Date:	08/09/2013
Disposition Status:	Filed
Implementation Date:	01/01/2014

State Filing Description:

Binders ANTP-CO14-125002891and ANTP-CO14-125002896

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: File & Use
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 08/09/2013
State Status Changed: 08/02/2013
Created By: Brenda Davis
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Brenda Davis

Filing Description:

This rate filing is for our new Anthem Dental Pediatric Adult Family Enhanced product that is intended for sale in the small group market on and off Exchange. Please see cover letter under Supporting Documentation for more information.

Company and Contact

Filing Contact Information

Brenda Davis,
3560 Delta Dental Dr
Eagan, MN 55122-3166

brenda.davis@wellpoint.com
651-994-5434 [Phone]

Filing Company Information

Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
700 Broadway
Denver, CO 80273
(303) 764-7273 ext. [Phone]

CoCode: 11011
Group Code: 671
Group Name:
FEIN Number: 84-0747736

State of Domicile: Colorado
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

State Specific

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*

Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*

Project Name/Number: */*

Please enter state-specific code(s) found in Colorado's Filing Requirements Bulletins, or on the General Instructions page. Please list all applicable state-specific codes. If no codes are applicable, please enter N/A.: N/A

All rate and loss cost filing types MUST be submitted with completed Rate Data Fields in accordance with Sections 10-4-401 and 10-16-107 C.R.S. This requirement does not apply to form filing types. Rate and loss cost filings not including this data will be rejected. If this is a rate or loss cost filing, have these fields been completed?: N/A

Have you completed the Forms Schedule Tab? ALL Life, Accident, and Health Rate and Form filing types require the Form Schedule Tab to be completed. In addition, all Form, Annual Form Certification, and Refund Calculation filing types require the Form Schedule Tab to be completed. The actual form must be attached to Form filing types only when filing: Medicare Supplement, Long-Term Care Partnership, Stop Loss, P&C Summary Disclosure Forms, and Workers Compensation. It is not necessary to submit the actual form for other lines of insurance. Thank you.: Yes

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates
Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Nichole Boggess	08/09/2013	08/09/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Amy Filler	07/16/2013	07/16/2013
Pending Industry Response	Cathy Gilliland	06/28/2013	06/28/2013
Pending Industry Response	Cathy Gilliland	06/20/2013	06/20/2013
Pending Industry Response	Cathy Gilliland	06/18/2013	06/18/2013

Response Letters

Responded By	Created On	Date Submitted
Brenda Davis	07/19/2013	07/19/2013
Brenda Davis	07/12/2013	07/12/2013
Brenda Davis	06/27/2013	06/27/2013
Brenda Davis	06/19/2013	06/19/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Rate	Dental Rate Manual for On Exchange	Brenda Davis	07/31/2013	07/31/2013
Rate	Dental Rate Manual for Off Exchange	Brenda Davis	07/31/2013	07/31/2013
Supporting Document	Actuarial Memorandum	Brenda Davis	07/31/2013	07/31/2013
Supporting Document	Crosswalk	Brenda Davis	07/31/2013	07/31/2013

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Disposition Letter	Note To Filer	Nichole Boggess	08/09/2013	08/09/2013
Regarding Response to Objection dated 7/16/13	Note To Reviewer	Brenda Davis	07/19/2013	07/19/2013
Duplicate objections	Note To Reviewer	Brenda Davis	06/28/2013	06/28/2013
objections	Note To Filer	Cathy Gilliland	06/28/2013	06/28/2013
Objection response to be submitted on 6/27	Note To Reviewer	Brenda Davis	06/26/2013	06/26/2013
act memo	Note To Filer	Cathy Gilliland	06/24/2013	06/24/2013
Request for Extension	Note To Reviewer	Brenda Davis	06/23/2013	06/23/2013
binder filing	Note To Filer	Cathy Gilliland	06/18/2013	06/18/2013

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 08/09/2013
Implementation Date: 01/01/2014
Status: Filed

Comment: State Tracking #278985
Company: Anthem Rocky Mtn. H&MS
Product Line: Small Group Dental PPO

Rate Implementation Summary
Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014

This is a new Filing for 2014 Standalone Dental plans, there is no rate change involved with this filing. The purpose of this rate filing is to establish new product rates for standalone dental plans that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Exchange if applicable.

Both On and Off Exchange Plans
Child Only Pediatric: 2 plans (Low AV Pediatric plan, High AV Pediatric plan)
Other Adult & Child: 2 family plans (Low AV plan, High AV plan)

Final Rate Filing Disposition
The Division has filed the rates in their final form after all adjustments.

See attached document for more information on this filing.

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #: *ANTV-129075587* **State Tracking #:** *278985* **Company Tracking #:**

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*

Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*

Project Name/Number: */*

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	HR-1 Form (H)		Yes
Supporting Document	HR-1 Form (H)		Yes
Supporting Document (revised)	Actuarial Memorandum		Yes
Supporting Document	Actuarial Memorandum		Yes
Supporting Document	Actuarial Memorandum		Yes
Supporting Document	Actuarial Memorandum		Yes
Supporting Document	Actuarial Memorandum		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Crosswalk		Yes
Form	Dental Benefit Policy for On Exchange		Yes
Form	Dental Benefit Policy for Off Exchange		Yes
Form	Dental Membership Enrollment For for Off Exchange		Yes
Rate (revised)	Dental Rate Manual for On Exchange		Yes
Rate	Dental Rate Manual for On Exchange		Yes
Rate	Dental Rate Manual		Yes
Rate	Dental Rate Manual		Yes
Rate	Dental Rate Manual		Yes
Rate (revised)	Dental Rate Manual for Off Exchange		Yes
Rate	Dental Rate Manual for Off Exchange		Yes

Final Disposition Letter

State Tracking #278985
Company: Anthem Rocky Mtn. H&MS
Product Line: Small Group Dental PPO

Rate Implementation Summary

Effective Date of New Rate Implementation: 1/1/2014 through 12/31/2014
This is a new Filing for 2014 Standalone Dental plans, there is no rate change involved with this filing.

The purpose of this rate filing is to establish new product rates for standalone dental plans that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Exchange if applicable.

Both On and Off Exchange Plans
Child Only Pediatric: 2 plans (Low AV Pediatric plan, High AV Pediatric plan)
Other Adult & Child: 2 family plans (Low AV plan, High AV plan)

Rate Methodology

Experience Used for Rate Setting: This is a new product. The “Prime / Complete Lite” was selected as a proxy for Anthem’s data. Enrollment started in April 2010 and has continued through June 2013.

2012 Experience Period Loss Ratio: 64% Loss Ratio with average annual premium = $32.41 based on 74,929 member months with $1,560,407 in incurred claims = $20.83 pmpm.

Annual Dental Cost Trends: 5.0%. This is 2.0% unit cost trend, and 1.5% utilization trend, and 1.5% mix trend for uninsured entering who will need immediate care.

Premium Retained to Cover Expenses, Taxes Fees and Profits

Administrative costs: Expenses the insurance company pays to operate this insurance plan.

This includes all expenses not directly related to paying claims, such as, but not limited to, salaries of company employees, the cost of the company’s offices and equipment, commissions
to agents to sell and service policies, subsidies to cover legally required plans such as portability, and taxes.

Profit: The amount of money remaining after claims and administrative expenses are paid. Margin is the comparable term for a nonprofit insurance company.

Premium retention is 29.46% shown as follows:
Admin Expenses: 12.0%
Commissions: 8.0%
State Premium Tax: 1.0%
Fed Health Insurer Fee: 2.46%
Profit & Contingency Margin: 6.0%

Sample of Final Premium Levels

					Boulder	
					Rating Area 1	
Company	Network Name	Plan Type	Level of Coverage	Age	Low	High
Rocky Mountain Hospital and Medical Serv	Dental Prime	PPO	High	0-20	$20.93	$25.58
				27	$21.93	$37.52
			Low	0-20	$17.46	$17.91
				27	$18.91	$24.31

Division Objections and Rate Changes During the Review Process

Anthem has answered all Division questions and provided all required support.

Final Rate Filing Disposition

The Division has filed the rates in their final form after all adjustments.

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/16/2013
Submitted Date	07/16/2013
Respond By Date	07/22/2013

Dear Brenda Davis,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

- Dental Rate Manual, [13-03271.06-SG, 13-03271.06-SG-EX] (Rate)

Comments: Please provide rate manuals that show the Plan Names/ID's with a clear crosswalk to the rates provided in the Rate Data Template. We also need the rate manual split for plans that will be offered on the exchange versus those offered off of the exchange.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 7/22/2013, which is within [20] calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 7/22/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, will result in the rate filing being DISAPPROVED on the basis that the rate filing is incomplete. Proposed rates may not be used in any manner until an adequate response to this objection has been received and the above referenced rate filing has been approved by the Division.

Sincerely,

Amy Filler

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/28/2013
Submitted Date	06/28/2013
Respond By Date	07/12/2013

Dear Brenda Davis,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (L) Trend-please provide the support for the trend assumptions. Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported.

1. Up to the four most recent years of monthly experience used to evaluate historical trends should be provided if available. This experience may be data for the plan being rated, or may include data from other Colorado or National business for similar lines of business, product designs, or benefit configurations.

2. The loss data for a health benefit plan or an applicable plan that pays on an expense basis must be on an incurred basis with pharmacy data shown separately from medical data, and showing separately the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The plan should indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. The claims experience for a health benefit plan or an applicable plan that pays on an expense basis should include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims, total medical incurred claims including estimated IBNR claims, actual pharmacy paid on incurred claims, total pharmacy incurred claims including estimated IBNR claims, average covered lives for medical, and average covered lives for pharmacy.

Objection 2

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (M) Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience.

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT {(# life years or claims)/full credibility standard}. The full credibility standard is defined above. Colorado data must still be provided.

2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

Objection 3

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (N) If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product. If no experience for the new product is available, experience for a comparable product must be provided,

Objection 4

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (P) Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; with projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should also be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

Objection 5

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (L) Please provide support for the the trend assumptions: Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported.

1. Up to the four most recent years of monthly experience used to evaluate historical trends should be provided if available. This experience may be data for the plan being rated, or may include data from other Colorado or National business for similar lines of business, product designs, or benefit configurations.

2. The loss data for a health benefit plan or an applicable plan that pays on an expense basis must be on an incurred basis with pharmacy data shown separately from medical data, and showing separately the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The plan should indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. The claims experience for a health benefit plan or an applicable plan that pays on an expense basis should include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims, total medical incurred claims including estimated IBNR claims, actual pharmacy paid on incurred claims, total pharmacy incurred claims including estimated IBNR claims, average covered lives for medical, and average covered lives for pharmacy

Objection 6

- Actuarial Memorandum (Supporting Document)

Comments: regulation 4-2-11 section 6 (M) Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience.

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT {(# life years or claims)/full credibility standard}. The full credibility standard is defined above. Colorado data must still be provided.

2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

Objection 7

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (N) Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years.

If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product. If no experience for the new product is available, experience for a comparable product must be provided,

Objection 8

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (P) Benefits Ratio Projections: The memorandum must contain a section projecting the

benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; with projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should also be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 07/12/2013, which is within 14 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 07/12/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Cathy Gilliland

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/20/2013
Submitted Date	06/20/2013
Respond By Date	06/24/2013

Dear Brenda Davis,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please correct the Implementation date requested to 1/1/14

Objection 2

Comments: Once a filing has been submitted, the Lead Form Number cannot be changed. For future filings, please ensure that the Lead Form Number field has been completed. For more information and guidance on how to update the form schedule tab, please contact the SERFF help desk.

Objection 3

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (H) Please provide the retention components on the Actuarial Memorandum.

Objection 4

- Actuarial Memorandum (Supporting Document)

Comments: Please provide the provision for profit and contingencies on the Actuarial Memoradum-Regulation 4-2-11 section 6 (J)

Objection 5

- Actuarial Memorandum (Supporting Document)

Comments: Your company's Actuarial Memorandum is not compliant with the current version of Colorado Regulation 4-2-11. EVERY item in Section 6 MUST be discussed. Also, it is now a requirement that the Actuarial Memorandum items MUST be presented in the order in which it is demonstrated in the regulation. Please review the current version of Colorado Regulation 4-2-11, found on our website, prior to submitting.

section (K) through (R) are missing.

Objection 6

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (H) The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

Benefits Ratio Guidelines

Comprehensive Major Medical (Individual) 75%

Comprehensive Major Medical (Small Group) 80%

Comprehensive Major Medical (Large Group) 85%

Comprehensive Major Medical (Student Blanket) 80%

Specified or Dread Disease 60%

Limited Benefit Plans 60%

Disability Income 60%

Dental/Vision 60%

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates
Project Name/Number: /

Stop Loss 60%
Short Term Limited Duration Health Insurance 60%

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/24/2013, which is within 4 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/24/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,
Cathy Gilliland

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	06/18/2013
Submitted Date	06/18/2013
Respond By Date	06/19/2013

Dear Brenda Davis,

Introduction:

This filing has been received, but before further action can be taken, please address the following:

Objection 1

Comments: Please submit a binder filing and a binder filing # by 6/19/2013

Conclusion:

Colorado Insurance Regulation 1-1-8 requires that every person shall provide a complete response in writing to any inquiry from the Division of Insurance. This reply must be submitted by 06/19/2013, which is within 1 calendar days from the date of this correspondence. If additional time is required to provide a complete response, including any documentation which is requested, a request for an extension of time must be submitted by 06/19/2013.

The request for an extension of time must state the reason for such request and the number of additional days required to provide a complete response. Requests for additional time will be granted for good cause shown and for a reasonable period at the discretion of the Division. Requests for an extension of time must be submitted through SERFF.

Failure to provide a full or complete response, or to request an extension for a specified period, may result in the imposition of a $500 fine under Colorado Insurance Regulation 1-1-8 and applicable surcharge pursuant to §24-34-108(2), C.R.S. This surcharge will be used to fund the development, implementation and maintenance of a consumer outreach and education program. Pursuant to Section 6 of Colorado Insurance Regulation 1-1-8, and after notice and hearing, additional sanctions may be sought under C.R.S. 10-1-215 and other fining and penalty provisions of Title 10.

Sincerely,

Cathy Gilliland

SERFF Tracking #:	ANTV-129075587	**State Tracking #:**	278985	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/19/2013
Submitted Date	07/19/2013

Dear Nichole Boggess,

Introduction:

Response 1

Comments:

Please see section Q (page 6) of the revised Dental Rate Manuals for a grid identifying the Plan Name/ID's from the Rate Data Template. Also, separate rate manuals and actuarial memorandums have been provided for on and off Exchange.

Related Objection 1

Applies To:

- Dental Rate Manual, [13-03271.06-SG, 13-03271.06-SG-EX] (Rate)

Comments: Please provide rate manuals that show the Plan Names/ID's with a clear crosswalk to the rates provided in the Rate Data Template. We also need the rate manual split for plans that will be offered on the exchange versus those offered off of the exchange.

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum for Off Exchange.pdf Actuarial Memorandum for On Exchange.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v3.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

SERFF Tracking #: *ANTV-129075587* **State Tracking #:** *278985* **Company Tracking #:**

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*

Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*

Project Name/Number: */*

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual for On Exchange	13-03271.06-SG-EX	New		Dental Rate Manual for On Exchange.pdf,	07/19/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v3.pdf,*	*07/12/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v2.pdf,*	*06/27/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*
2	Dental Rate Manual for Off Exchange	13-03271.06-SG	New		Dental Rate Manual for Off Exchange.pdf,	07/19/2013 By: Brenda Davis

Conclusion:

Sincerely,
Brenda Davis

SERFF Tracking #:	ANTV-129075587	**State Tracking #:**	278985	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/12/2013
Submitted Date	07/12/2013

Dear Nichole Boggess,

Introduction:

Thank you for the opportunity to respond.

Response 1

Comments:

To comply with 4-2-11 section 6 (L) the actuarial memorandum has been revised.

Related Objection 1

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (L) Trend-please provide the support for the trend assumptions. Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported.

1. Up to the four most recent years of monthly experience used to evaluate historical trends should be provided if available. This experience may be data for the plan being rated, or may include data from other Colorado or National business for similar lines of business, product designs, or benefit configurations.

2. The loss data for a health benefit plan or an applicable plan that pays on an expense basis must be on an incurred basis with pharmacy data shown separately from medical data, and showing separately the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The plan should indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. The claims experience for a health benefit plan or an applicable plan that pays on an expense basis should include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims, total medical incurred claims including estimated IBNR claims, actual pharmacy paid on incurred claims, total pharmacy incurred claims including estimated IBNR claims, average covered lives for medical, and average covered lives for pharmacy.

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v3.pdf,	07/12/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v2.pdf,*	*06/27/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 2

Comments:

To comply with 4-2-11 section 6 (M) the actuarial memorandum has been revised.

Related Objection 2

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (M) Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience.

1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT {(# life years or claims)/full credibility standard}. The full credibility standard is defined above. Colorado data must still be provided.

2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v3.pdf,	07/12/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v2.pdf,*	*06/27/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 3

Comments:

To comply with 4-2-11 section 6 (N) the actuarial memorandum has been revised.

Related Objection 3

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (N) If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product. If no experience for the new product is available, experience for a comparable product must be provided,

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v3.pdf,	07/12/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v2.pdf,*	*06/27/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 4

Comments:

To comply with 4-2-11 section 6 (P) the actuarial memorandum has been revised.

Related Objection 4

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (P) Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; with projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should also be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v3.pdf,	07/12/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v2.pdf,*	*06/27/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 5

Comments:

Duplicate objection.

Related Objection 5

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (L) Please provide support for the the trend assumptions: Trend: This section must describe the trend assumptions used in pricing. These assumptions must each be separately discussed, adequately supported, and also be appropriate for the specific line of business, product design, benefit configuration, and time period. Any and all factors affecting the projection of future claims must be presented and adequately supported.

1. Up to the four most recent years of monthly experience used to evaluate historical trends should be provided if available. This experience may be data for the plan being rated, or may include data from other Colorado or National business for similar lines of business, product designs, or benefit configurations.

2. The loss data for a health benefit plan or an applicable plan that pays on an expense basis must be on an incurred basis with pharmacy data shown separately from medical data, and showing separately the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and incurred but not reported (IBNR) reserves) as of the valuation date. The plan should indicate the number of paid claim months of run out used beyond the end of the incurred claims period.

3. The claims experience for a health benefit plan or an applicable plan that pays on an expense basis should include the following separate data elements for each month: actual medical (non-pharmacy) paid on incurred claims, total medical incurred claims including estimated IBNR claims, actual pharmacy paid on incurred claims, total pharmacy incurred claims including estimated IBNR claims, average covered lives for medical, and average covered lives for pharmacy

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates
Project Name/Number: /

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v3.pdf,	07/12/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v2.pdf,*	*06/27/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 6

Comments:

Duplicate objection.

Related Objection 6

Applies To:

- *Actuarial Memorandum (Supporting Document)*

SERFF Tracking #:	ANTV-129075587	**State Tracking #:**	278985	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates		
Project Name/Number:	/		

Comments: regulation 4-2-11 section 6 (M) Credibility: The Colorado standard for fully credible data is 2,000 life years and 2,000 claims. Both standards must be met within a maximum of three years, if the proposed rates are based on claims experience.
1. The memorandum shall discuss the credibility of the Colorado data with the proposed rates based upon as much Colorado data as possible. Collateral data used to support partially credible Colorado data, including published data sources (including affiliated carriers) must be provided and applicability of the use of such data must be discussed. The use of collateral data is only acceptable if the Colorado data does not meet the full credibility standard. The formula for determining the amount of credibility to assign to the data is SQRT {(# life years or claims)/full credibility standard}. The full credibility standard is defined above. Colorado data must still be provided.
2. The memorandum shall also discuss how and if the aggregated data meets the Colorado credibility requirement. Any filing, which bases its conclusions on partially credible data, should include a discussion as to how the rating methodology was modified for the partially credible data.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments:

Duplicate objection.

SERFF Tracking #:	ANTV-129075587	**State Tracking #:**	278985	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates		
Project Name/Number:	/		

Related Objection 7

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (N) Data Requirements: The memorandum must, at a minimum, include earned premium, incurred claims, actual benefits ratio, number of claims, average covered lives and number of policyholders submitted on a Colorado-only basis for at least 3 years.
If the filing is to introduce a new product to Colorado, nationwide experience must be provided for this product. If no experience for the new product is available, experience for a comparable product must be provided,

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 8

Comments:

Duplicate objection.

Related Objection 8

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (P) Benefits Ratio Projections: The memorandum must contain a section projecting the benefits ratio, over the rating period, both with and without the requested rate change. The comparison should be shown in chart form; with projected premiums, projected incurred claims and projected benefits ratio over the rating period, both with and without the requested rate change. The corresponding projection calculations should also be included. For products priced using a lifetime loss ratio standard, such as long-term care, Medicare supplement and long term disability, the projections should include a timeframe as to when the lifetime loss ratio will be achieved.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v3.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please contact me if you have any questions or need additional information to complete your review.

Sincerely,

Brenda Davis

SERFF Tracking #:	ANTV-129075587	**State Tracking #:**	278985	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/27/2013
Submitted Date	06/27/2013

Dear Nichole Boggess,

Introduction:

Thank you for the opportunity to respond.

Response 1

Comments:

A Post-Submission Update has been submitted to revise the Implementation Date to 01/01/2014.

Related Objection 1

Comments: Please correct the Implementation date requested to 1/1/14

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

The plan has notated this requirement and will comply in future filings.

Related Objection 2

Comments: Once a filing has been submitted, the Lead Form Number cannot be changed. For future filings, please ensure that the Lead Form Number field has been completed. For more information and guidance on how to update the form schedule tab, please contact the SERFF help desk.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

No Rate/Rule Schedule items changed.

Response 3

Comments:

To comply with Regulation 4-2-11 section 6(H), a new Actuarial Memorandum has been provided, which provides retention components.

Related Objection 3

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (H) Please provide the retention components on the Actuarial Memorandum.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v2.pdf,	06/27/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 4

Comments:

To comply with Regulation 4-2-11 section 6(J), a new Actuarial Memorandum has been provided, which provides a provision for profit and contingencies.

Related Objection 4

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Please provide the provision for profit and contingencies on the Actuarial Memoradum-Regulation 4-2-11 section 6 (J)

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v2.pdf,	06/27/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 5

Comments:

To comply with Regulation 4-22-11, a new Acturial Memorandum has been included in the filing, which addresses all items in Section 6, and presented in the format as required.

Related Objection 5

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Your company's Actuarial Memorandum is not compliant with the current version of Colorado Regulation 4-2-11. EVERY item in Section 6 MUST be discussed. Also, it is now a requirement that the Actuarial Memorandum items MUST be presented in the order in which it is demonstrated in the regulation. Please review the current version of Colorado Regulation 4-2-11, found on our website, prior to submitting.

section (K) through (R) are missing.

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v2.pdf,	06/27/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Response 6

Comments:

To comply with Regulation 4-2-11 section 6(H), a new Actuarial Memorandum and Dental Rate Manual have been added to the filing.

Related Objection 6

Applies To:

- Actuarial Memorandum (Supporting Document)

Comments: Regulation 4-2-11 section 6 (H) The Division recommended benefits ratio guidelines are as listed below. Targeted benefits ratios below these guidelines shall be actuarially justified.

Benefits Ratio Guidelines
Comprehensive Major Medical (Individual) 75%
Comprehensive Major Medical (Small Group) 80%
Comprehensive Major Medical (Large Group) 85%
Comprehensive Major Medical (Student Blanket) 80%
Specified or Dread Disease 60%
Limited Benefit Plans 60%
Disability Income 60%
Dental/Vision 60%
Stop Loss 60%
Short Term Limited Duration Health Insurance 60%

Changed Items:

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Previous Version	
Satisfied - Item:	*HR-1 Form (H)*
Comments:	
Attachment(s):	*HR-1 SG.pdf*

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

No Form Schedule items changed.

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual	13-03271.06-SG, 13-03271.06-SG-EX	New		Dental Rate Manual v2.pdf,	06/27/2013 By: Brenda Davis
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*

Conclusion:

Sincerely,
Brenda Davis

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	06/19/2013
Submitted Date	06/19/2013

Dear Nichole Boggess,

Introduction:

Thank you for the opportunity to respond.

Response 1

Comments:

The dental binder has been filed by our medical counterparts under SERFF tracking number ANTP-CO14-125002921.

Related Objection 1

Comments: Please submit a binder filing and a binder filing # by 6/19/2013

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Please let me know if you have any questions or need additional information. Thank you!

Sincerely,

Brenda Davis

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Amendment Letter

Submitted Date: 07/31/2013

Comments:

Per meeting between the plan's actuary and the Department on July 29, 2013, we are amending the filing to include a revised memorandum that more clearly indicates how rates were configured and provided additional tables. A "crosswalk" document has also been added to the supporting documents tab, per the Department's request.

Changed Items:

No Form Schedule Items Changed.

SERFF Tracking #: ANTV-129075587 **State Tracking #:** 278985 **Company Tracking #:**

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental

Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates

Project Name/Number: /

Rate/Rule Schedule Item Changes

Item No.	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments	Date Submitted
1	Dental Rate Manual for On Exchange	13-03271.06-SG-EX	New		Dental Rate Manual for ON Exchange v2.pdf,	07/31/2013 By:
Previous Version						
1	*Dental Rate Manual for On Exchange*	*13-03271.06-SG-EX*	*New*		*Dental Rate Manual for On Exchange.pdf,*	*07/19/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v3.pdf,*	*07/12/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual v2.pdf,*	*06/27/2013 By: Brenda Davis*
Previous Version						
1	*Dental Rate Manual*	*13-03271.06-SG, 13-03271.06-SG-EX*	*New*		*Dental Rate Manual.pdf,*	*06/14/2013 By: Brenda Davis*
2	Dental Rate Manual for Off Exchange	13-03271.06-SG	New		Dental Rate Manual for OFF Exchange v2.pdf,	07/31/2013 By:
Previous Version						
2	*Dental Rate Manual for Off Exchange*	*13-03271.06-SG*	*New*		*Dental Rate Manual for Off Exchange.pdf,*	*07/19/2013 By: Brenda Davis*

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedule Item Changes	
Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum for OFF Exchange v2.pdf Actuarial Memorandum for ON Exchange v2.pdf
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum for Off Exchange.pdf* *Actuarial Memorandum for On Exchange.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v3.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum v2.pdf*
Previous Version	
Satisfied - Item:	*Actuarial Memorandum*
Comments:	
Attachment(s):	*Actuarial Memorandum.pdf*

Satisfied - Item:	Crosswalk
Comments:	
Attachment(s):	Crosswalk for Ids.xlsx

SERFF Tracking #:	ANTV-129075587	**State Tracking #:**	278985	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates		
Project Name/Number:	/		

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates
Project Name/Number: /

Note To Filer

Created By:

Nichole Boggess on 08/09/2013 10:01 AM

Last Edited By:

Nichole Boggess

Submitted On:

08/09/2013 10:01 AM

Subject:

Disposition Letter

Comments:

Revised disposition letter sent

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

Note To Reviewer

Created By:

Brenda Davis on 07/19/2013 12:13 PM

Last Edited By:

Nichole Boggess

Submitted On:

08/02/2013 10:18 AM

Subject:

Regarding Response to Objection dated 7/16/13

Comments:

Dear Reviewer,

Please note, the Plan Name/ID's from the Rate Data Template are included in section Q, page 6 of the Actuarial Memorandum, and not the Dental Rate Manual as stated in the objection response. Thank you!

Regards,
Brenda Davis

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

Note To Reviewer

Created By:

Brenda Davis on 06/28/2013 10:59 AM

Last Edited By:

Nichole Boggess

Submitted On:

08/02/2013 10:18 AM

Subject:

Duplicate objections

Comments:

The duplicate objections have been noted and we will disregard. Thank you!

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

Note To Filer

Created By:

Cathy Gilliland on 06/28/2013 10:41 AM

Last Edited By:

Nichole Boggess

Submitted On:

08/02/2013 10:18 AM

Subject:

objections

Comments:

looks like objections were duplicated-please dismiss the duplication

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

Note To Reviewer

Created By:

Brenda Davis on 06/26/2013 09:31 AM

Last Edited By:

Nichole Boggess

Submitted On:

08/02/2013 10:18 AM

Subject:

Objection response to be submitted on 6/27

Comments:

Dear Reviewer,

This is a note to confirm that, per our phone conversation, our objection response with updated actuarial memorandum will be submitted by 6/27/2013. Thank you!

Regards,
Brenda Davis

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

Note To Filer

Created By:

Cathy Gilliland on 06/24/2013 08:51 AM

Last Edited By:

Nichole Boggess

Submitted On:

08/02/2013 10:18 AM

Subject:

act memo

Comments:

The filing cannot be looked at for completeness without a correct Act Memo-please provide by 6/27/2013

State: Colorado **Filing Company:** Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield

TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: Anthem Dental Pediatric Adult Family Enhanced SG Rates
Project Name/Number: /

Note To Reviewer

Created By:

Brenda Davis on 06/23/2013 07:19 AM

Last Edited By:

Nichole Boggess

Submitted On:

08/02/2013 10:18 AM

Subject:

Request for Extension

Comments:

Respectfully, the plan requests an extension until 6/26/2013 to respond to the objection letter submitted on 6/20/2013, so that the actuary team may properly address the objections regarding the actuarial memorandum. Please advise. Thank you!

State: *Colorado* **Filing Company:** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

Note To Filer

Created By:

Cathy Gilliland on 06/18/2013 11:37 AM

Last Edited By:

Nichole Boggess

Submitted On:

08/02/2013 10:18 AM

Subject:

binder filing

Comments:

a binder filing must be submit with a dental rate filing-please submit by 6/19/2013 and provide a binder filing #-left phone message 6/18/2013

State: *Colorado* ***Filing Company:*** *Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*

TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *Anthem Dental Pediatric Adult Family Enhanced SG Rates*
Project Name/Number: */*

Post Submission Update Request Processed On 06/28/2013

Status:	Allowed
Created By:	Brenda Davis
Processed By:	Cathy Gilliland
Comments:	

General Information:

Field Name	Requested Change	Prior Value
Requested Filing Mode	File & Use	Review & Approval
Implementation Date Requested	01/01/2014	10/01/2013

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Dental Benefit Policy for On Exchange	13-03271.06-SG-EX	CER	Initial		50.100	
2		Dental Benefit Policy for Off Exchange	13-03271.06-SG	CER	Initial		50.100	
3		Dental Membership Enrollment For for Off Exchange	09-04114.06	AEF	Initial		50.000	

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:	Review and Approve
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	0.000%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	n/a

Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Dental Rate Manual for On Exchange	13-03271.06-SG-EX	New		Dental Rate Manual for ON Exchange v2.pdf,
2		Dental Rate Manual for Off Exchange	13-03271.06-SG	New		Dental Rate Manual for OFF Exchange v2.pdf,

Anthem Blue Cross Blue Shield

ANTHEM DENTAL RATE MANUAL

Anthem Dental Pediatric/Adult/Family Products

Table of Contents

Schedule of Benefits
The following schedules of benefits will be made available to individuals depending on the member's age. Note that the schedule of benefits, for the non-participating provider benefit schedule could be different than the participating provider benefit schedule. Also, the schedule of benefits could be different for Adult members and Pediatric members.

Anthem Dental Pediatric/Adult/Family

Adult Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative*	NC or 10% to 90%
Endodontics*	NC or 10% to 90%
Periodontics*	NC or 10% to 90%
Oral Surgery*	NC or 10% to 90%
Major Restorative*	NC or 10% to 60%
Prosthetic Repairs/Adjustments*	NC or 10% to 60%
Prosthetics*	NC or 10% to 60%
Orthodontics*	NC

* NC denotes no coverage

Individual Deductible	$50 per person
Family Deductible	$50 per person
Annual Maximum	$500 - $2,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Deductible levels available at $50 at the individual level.
Annual maximum available within the range in increments of $250.
Annual Out-Of-Pocket (OOP) Maximum is not available.

Pediatric Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative	50% to 90%
Endodontics	50% to 90%
Periodontics	50% to 90%
Oral Surgery	50% to 90%
Major Restorative	50% to 60%
Prosthetic Repairs/Adjustments	50% to 60%
Prosthetics	50% to 60%
Dentally Necessary Orthodontics	50% to 60%
Cosmetic Orthodontics*	NC or 50% to 60%

* NC denotes no coverage

Individual Deductible	$50
Family Deductible	$50 per person
Annual Maximum	N/A for Participating Providers; $1,000 for Non-Participating Providers
Annual Out of Pocket Maximum Individual/Family	$700/$1,400
Dentally Necessary Orthodontics Maximum	No Maximum for Participating Providers; $1,000 LT Max for Non-Participating Providers
Cosmetic Orthodontia Lifetime Maximum	$1,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Annual Out-Of-Pocket (OOP) Maximum on Pediatric EHB plans of $700 per member up to a maximum of $1,400 per family.

Plan Options Available

- Cosmetic Orthodontia is included with the Anthem Dental Family Enhanced Plan for children age 8 up to age 19
- Annual OOP Maximum may be $1,000 per member up to a maximum of $2,000 per family

Individual Dental Rate Manual Instructions

All calculations can be completed in the following Anthem Dental Rating Worksheet (see Exhibit 1). Linear interpolation is to be followed to derive the appropriate factors for benefits not explicitly given in this rate manual.

Step 1: Fill in the benefit plan information: the Individual's name, the product selected, location, and the effective date of the contract. Note that the benefits may vary between the participating provider columns and the non-participating columns as well as between Adult and Pediatric columns. Note that 100/80/50 denotes coverage at 100% for Diagnostic and Preventive (Class I), 80% coverage for Basic Restorative (Class II), and 50% coverage for Major Restorative (Class III).

Step 2: Coinsurance Adjustment Coinsurance adjustment factors (see TABLE-1) are given for different combinations of services. Based on the plan's benefits, find the appropriate set of coinsurance adjustment factors in TABLE-1A & TABLE-1B for Pediatric and Adult benefits respectively, and enter them in the appropriate coinsurance adjustment worksheet (Exhibits 4A & 4B) and enter the results of coinsurance adjustment worksheet into the coinsurance adjustment row of the rating worksheet.

Step 3: Multiply the Adult and Pediatric starting claim cost by the appropriate coinsurance adjustment factor for each class of service. Enter the results on the line in Exhibit 1 labeled "Adjusted starting claim cost". On the line labeled "Combined claim cost" enter the sum of the Class I, Class II, and Class III adjusted starting claim costs.

Step 4: Enter the Deductible adjustment from TABLE-2. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to a deductible and that is reflected in the Pediatric starting claim costs.

Step 5: Based on the plans annual maximum benefit, enter the appropriate annual maximum adjustment factor from TABLE-3. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to an annual max and that is reflected in the Pediatric starting claim costs.

Step 6: Geographic Area Adjustment: Refer to TABLE-4, and pick the appropriate factor based on the three-digit zip code the member resides in. Enter the factor on the rating sheet.

Step 7: Annual Trend The starting claim costs were developed with a baseline date of July 1, 2012. Claim costs are expected to increase at a trend of 5.00% annually in half month increments. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$. Enter the compounded trend amount on the annual trend line on the rating worksheet. For example if the quote applies to period of January 1st, 2014 to December 31st, 2014, the trend period is from July 1st, 2012 to June 30th, 2014 (the mid-point of the rating period), or 48 half months.

Step 8: For benefit plan designs that include waiting periods for certain benefit categories, the appropriate factor in TABLE-5 will be entered in the columns on the line labeled "Benefit Waiting Period factor". For Pediatric plans, the factor is 1.00 because the Pediatric benefits are not subject to waiting periods and that is reflected in the Pediatric starting claim costs.

Step 9: Reimbursement Factor: Refer to TABLE-6, and pick the appropriate factor based on the member's three-digit zip code and enter it on the rating sheet. The same factor will be used in the in the participating provider columns and the non-participating provider columns for both Pediatric and Adult plans.

Step 10: Provider Usage Factor: Refer to TABLE-7, and enter the provider usage factors in the appropriate columns.

Step 11: Out-of-Pocket Maximum Factor: The Pediatric dental benefit has an annual Out-of-Pocket Maximum of $700 for an individual up to a limit of $1,400 for the family priced into the Pediatric dental product and has a factor of 1.00 in the rating worksheet. If a $1,000 Out-of-Pocket Maximum for an individual up to a limit of $2,000 for the family members up to the age of 19 is used, a factor of .975 is used for the Out-of-Pocket Maximum factor line in the Pediatric columns in the rating worksheet.

Step 12: Family Factor: Enter the appropriate Family Factor from TABLE-8 depending on the product that is purchased. For purchasers of an Anthem Dental Family product, the Family Factor is to account for administrative efficiencies and decreased anti-selection risk of a family purchasing instead of individual purchasers of separate Pediatric and Adult policies.

Step 13: On the line labeled "Total Claim Cost", enter the product of multiplying the combined claim cost from step 3 by the factors in steps 4 through 12.

Step 14: Retention: Enter 1 minus the retention amount from TABLE-9. The expected loss ratio for this product is 70.54% for On-Exchange.

Step 15: On the line labeled "Gross Monthly Premium": enter the result of dividing the amount from step 13 by the amount in step 14.

Step 16: Blended Premium: To determine the blended premium rate, add the results from step 14, for the Participating Provider column, and the Non-Participating Provider column. Do this for both the Pediatric and Adult columns.

Step 17: Ortho Premium: The orthodontia premium is calculated in Exhibit 5. Dentally Necessary Orthodontia is included in all Pediatric plans and is the Pediatric class IV claim cost. This amount should be entered into the line 1 of Exhibit 5 under the Pediatric column. For the Anthem Dental Family Enhanced product, cosmetic orthodontia is included for members age 8 up to age 19 and the claim cost of the cosmetic orthodontia is located in TABLE-10 and entered in line 2 of Exhibit 5 in both the Pediatric and Adult columns. The sum of the costs for the Pediatric and Adult costs are entered in line 3 of Exhibit 5. In line 4 of Exhibit 4, enter 1 minus the retention percentage from TABLE-9. In Exhibit 5, line 5 equals

line 3 divided by line 4 to give the orthodontia premium amount to enter for the Orthodontia Premium in the rating worksheet.

Step 18: Final Premium Rates: Enter the sum of the Blended Premium Rate and Ortho Premium from step 16 and step 17 and enter into the Final Premium Rate for both the Pediatric and Adult columns.

Step 19: For the Anthem Dental Pediatric and Anthem Dental Adult products, the rates from step 18 are the rates to use multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. For the Anthem Dental Family products, Exhibit 3 is used to calculate the number of pediatric and adult premiums that will be rated for based on the makeup of the family, and the resulting values from Exhibit 3 are used in the Rating Worksheet for the Number of Pediatric Premiums and the Number of Adult Premiums, respectively. The Total Contract Premium is calculated by multiplying the rates in the Pediatric column from step 18 by the Number of Pediatric Premiums and adding the product of the Final Premium Rate in the Adult column from step 18 and the Number of Adult Premiums.

TABLE - 1A
Pediatric Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.1111	1.020	100%	2.000	1.050	100%	2.000	1.100
90%	1.0000	1.000	80%	1.600	1.041	50%	1.000	1.000
80%	0.8889	0.990	60%	1.200	1.010			
70%	0.7778	0.980	50%	1.000	1.000			

Default plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4A for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 1B
Adult Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.0000	1.000	90%	1.800	1.046	60%	1.200	1.030
90%	0.9000	0.993	80%	1.600	1.026	50%	1.000	1.000
80%	0.8000	0.992	60%	1.200	1.005	30%	0.600	0.965
75%	0.7500	0.988	50%	1.000	1.000	25%	0.500	0.955
50%	0.5000	0.970	30%	0.600	0.974	15%	0.300	0.945
			25%	0.500	0.964	0%	0.000	0.000
			15%	0.300	0.944			
			0%	0.000	0.000			

Default plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4B for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 2

Benefit Year Deductible Factors

	Factor
Deductible does not apply to Diagnostic and Preventive Services	1.00
Deductible does apply to Diagnostic and Preventive Services	0.95

Note:
A $50 per person deductible will apply to any Adult benefit set. The only variable regarding the deductible is whether or not the deductible applies to Diagnostic and Preventive Services. A $50 deductible applies to non-D&P services for Pediatric plans.

TABLE - 3

Annual Maximum Benefit Factors

Annual Maximum Amount	Factor
$500	0.9100
$750	0.9400
$1,000	0.9690
$1,200	1.0000
$1,250	1.0078
$1,500	1.0600
$1,750	1.0950
$2,000	1.1300
$2,500	1.2200

Note: For a quote that has D & P coverage only, annual maximum factors for all amounts equals amounts equals 1.00. Pediatric plans do not have an annual max therefore have a factor of 1.00 because the unlimted maximum is built into the starting claim cost.

TABLE - 4

Geographic Area Adjustment

Rating Area	Factor
Statewide	1.020

TABLE - 5

Benefit Waiting Period Factors

Services Covered	Factor
6 month waiting period on Basic Restorative and 12 month on non-D&P	0.975
12 month waiting period on Class III Only	1.000
Class I, Class II, and Class III are all covered with no waiting period	1.050

Note: Pediatric plans do not have waiting periods on non-orthodontia services therefore get a factor of 1.00.

TABLE - 6

Reimbursement Factors

Rating Area - Three-Digit Zips Included	Factor
Statewide	
Prime Network Reimbursement Factor	0.700
Non-Participating Reimbursement Factor	0.700

TABLE-7

Provider Usage Factors

Rating Area - Three-Digit Zips Included	**Factor**
Statewide	
Prime Network Usage Factor	0.507
Non-Participating Usage Factor	0.493

TABLE - 8

Family Factor

Product	**Factor**
Anthem Dental Pediatric Products	1.0000
Anthem Dental Adult Products	1.0000
Anthem Dental Family Products	0.9750

TABLE - 9

Retention Factor

	Retention as % of Premium	
	On-Exchange	Off-Exchange
Administration Expense	12.00%	12.00%
Premium Tax	1.00%	1.00%
ACA Insurer Fee	2.46%	2.46%
Exchange Fee	0.00%	0.00%
Commission	8.00%	8.00%
Profit / Risk Charge	6.00%	6.00%
Retention	**29.46%**	**29.46%**

TABLE - 10

Orthodontia Claim Costs

Orthodontia Benefit	**Claim Cost**
Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.36
Cosmetic Orthodontia per member per month cost $1,000 Lifetime Maximum with 12 Month Waiting Period Costemic Orthodontia is all orthodontia cases not deemed Dentally Necessary Orthodontia	$3.65
Dentally Necessary with no cost share for AV calculation Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.54

Exhibit 1 -- Individual Dental Rating Worksheet

Name	Product
Location (Zip Code)	Effective Date

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1												
Adjusted starting claim cost		Product of above 2 lines												
Combined Claim Cost		Sum of the 3 Classes												
Deductible adjustment		Refer to TABLE-2												
Annual maximum adjustment		Refer to TABLE-3												
Geographic area adjustment		Refer to TABLE-4												
Annual trend		Refer to Step 7												
Benefit waiting period factor		Refer to TABLE-5												
Reimbursement factor		Refer to TABLE-6												
Provider Usage factor		Refer to TABLE-10												
Out-Of-Pocket Max Factor		Refer to Step 11												
Family Factor		Refer to TABLE-8												
Total Claim Cost		Product of Combined Claims Cost factors and adjustments												
Retention	29.46%	Refer to TABLE-9	70.54%			70.54%			70.54%			70.54%		
Gross Monthly Premium		Total claim cost divided by (1 - Retention)	$0.00			$0.00			$0.00			$0.00		

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program		
Non-Participating Program		
Total	**$0.00**	**$0.00**

Ortho Premium	Refer to Exhibit 4 and Step 17	Pediatric	Adult
Total			

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total			

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total				**$0.00**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name	J. Doe
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6500	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.0200	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-10		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 4 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 3 -- Anthem Dental Family Product -- Number of Rates Worksheet

Name	J. Doe
Product	Anthem Dental Family Enhanced

Number of members in family	6
Number of non-child members (a)	2
Number of child members age 19 and older (b)	2
Number of child members under age 19 (c)	2

Number of non-child members to be rated (d):	2
Take the number (a)	
Number of children age 19 and older to be rated (e):	2
Take the lesser of (b) and 3	
Number of children age under age 19 to be rated (f)	1
Take the lesser of 3 minus (d) or (c)	

Number number of adult premiums rated	**4**
Take the sum of (d) and (e)	
Number of pediatric premiums to be rated for (f)	**1**

Exhibit 4A -- Pediatric Dental Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	90	50	50	50
3 Claim Impact Factors (Table-1)	1.111	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0200	1.0410	1.0000	1.0000
5 Total Change	1.1333	1.6656	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.6260	0.3740	1.0000
7 Total Weighted Change	1.1333	1.0427	0.3740	1.0000
8 Coinsurance Factor for Exhibit1	1.1333	1.4167		1.0000

Baseline plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 4B -- Adult Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	100	50	50	50
3 Claim Impact Factors (Table-1)	1.000	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0000	1.0260	1.0000	1.0000
5 Total Change	1.0000	1.6416	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.5283	0.4717	1.0000
7 Total Weighted Change	1.0000	0.8673	0.4717	1.0000
8 Coinsurance Factor for Exhibit1	1.0000	1.3390		1.0000

Baseline plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 5 -- Orthodontia Premium Worksheet		
Product		
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)		
Cosmetic Orthodontia (line 2)		
Total Orthodontia Claim Cost (line 3)		
Retention (line 4)		
Orthodontia Premium (line 5)		

Exhibit 6 -- Orthodontia Premium Worksheet -- Sample Calculation		
Product	Anthem Dental Family Enhanced	
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)	$0.39	$0.00
Cosmetic Orthodontia (line 2)	$3.65	$3.65
Total Orthodontia Claim Cost (line 3)	4.04	3.65
Retention (line 4)	70.54%	70.54%
Orthodontia Premium (line 5)	5.73	5.17

Exhibit 7

Development and Justification for Administrative Expense Load and Commission Load

Colorado Prime Network Products

These Prime Network dental products are administered by DeCare Dental which is a wholly owned subsidiary of WellPoint Inc. Anthem Blue Cross Blue Shield of Colorado is also a subsidiary of WellPoint Inc.

ADMINISTRATIVE EXPENSE

(a)	DeCare Dental administers a large block of small group dental risk products. Total incurred costs for administrative expenses for 2010 for the small group dental risk business administered by DeCare dental was:	$19,279,150
(b)	Total earned premium for 2010 for the small group dental risk business administered by DeCare Dental and mentioned in (a) above was:	$126,399,305
(c)	Incurred administrative costs as a percent of earned premium for 2010 for DeCare Dental's small group dental risk business was (a)/(b) which equals:	15.25%
(d)	Average annual premium per member per month (PMPM) for the small group dental business administered by DeCare Dental:	$24.43
(e)	Average monthly premium per member per month (PMPM) for the HCR compliant Prime Network business expected in Colorado:	$30.87
(f)	Ratio of average premium PMPM for DeCare small group business to expected average PMPM premium for Colorado Prime Network HCR business, equals (d) / (e):	0.791
(g)	Since the average expected Colorado dental premium is greater than the average DeCare small group dental premium, a lower percent of premium is needed to generate the needed administrative expense to operate the CO small group Prime % Complete business. That percentage is equal to (f) x (c) which equals:	12.07%

Anthem Blue Cross Blue Shield (BCBS) of Colorado does have a block of small group dental risk business. Below is some data regarding that business.

COMMISSION EXPENSE

(a)	Earned premium for 2012 for Anthem BCBS of Colorado small group dental business:	$5,229,195
(b)	Incurred commissions for 2012 for Anthem BCBS small group dental business:	$550,514
(c)	Ratio of commissions to premium for 2012 for Anthem BCBS small group dental	10.53%

(d) The 10.53% commission percentage above is a result of the commissions that were paid for Anthem BCBS's small group dental business in 2012. Generally most of the products have a 10% commission for the writing agent, and there are a few agreements in place in which a managing general agent receives a commission override. So, the commission in (c) above is made up of a 10% writing agent commission and a .43% commission override.
For the new Prime Network dental products, some of the sales will be made directly by the consumer without any compensation paid to a broker or a navigator, thereby having no commission expense. With this in mind, we are expecting an average commission rate for these HCR compliant products to be sold on and off exchange to be 8%.

Anthem Blue Cross Blue Shield

ANTHEM DENTAL RATE MANUAL

Anthem Dental Pediatric/Adult/Family Products

Table of Contents

Schedule of Benefits
The following schedules of benefits will be made available to individuals depending on the member's age. Note that the schedule of benefits, for the non-participating provider benefit schedule could be different than the participating provider benefit schedule. Also, the schedule of benefits could be different for Adult members and Pediatric members.

Anthem Dental Pediatric/Adult/Family

Adult Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative*	NC or 10% to 90%
Endodontics*	NC or 10% to 90%
Periodontics*	NC or 10% to 90%
Oral Surgery*	NC or 10% to 90%
Major Restorative*	NC or 10% to 60%
Prosthetic Repairs/Adjustments*	NC or 10% to 60%
Prosthetics*	NC or 10% to 60%
Orthodontics*	NC

* NC denotes no coverage

Individual Deductible	$50 per person
Family Deductible	$50 per person
Annual Maximum	$500 - $2,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Deductible levels available at $50 at the individual level.
Annual maximum available within the range in increments of $250.
Annual Out-Of-Pocket (OOP) Maximum is not available.

Pediatric Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative	50% to 90%
Endodontics	50% to 90%
Periodontics	50% to 90%
Oral Surgery	50% to 90%
Major Restorative	50% to 60%
Prosthetic Repairs/Adjustments	50% to 60%
Prosthetics	50% to 60%
Dentally Necessary Orthodontics	50% to 60%
Cosmetic Orthodontics*	NC or 50% to 60%

* NC denotes no coverage

Individual Deductible	$50
Family Deductible	$50 per person
Annual Maximum	N/A for Participating Providers; $1,000 for Non-Participating Providers
Annual Out of Pocket Maximum Individual/Family	$700/$1,400
Dentally Necessary Orthodontics Maximum	No Maximum for Participating Providers; $1,000 LT Max for Non-Participating Providers
Cosmetic Orthodontia Lifetime Maximum	$1,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Annual Out-Of-Pocket (OOP) Maximum on Pediatric EHB plans of $700 per member up to a maximum of $1,400 per family.

Plan Options Available

- Cosmetic Orthodontia is included with the Anthem Dental Family Enhanced Plan for children age 8 up to age 19
- Annual OOP Maximum may be $1,000 per member up to a maximum of $2,000 per family

Individual Dental Rate Manual Instructions

All calculations can be completed in the following Anthem Dental Rating Worksheet (see Exhibit 1). Linear interpolation is to be followed to derive the appropriate factors for benefits not explicitly given in this rate manual.

Step 1: Fill in the benefit plan information: the Individual's name, the product selected, location, and the effective date of the contract. Note that the benefits may vary between the participating provider columns and the non-participating columns as well as between Adult and Pediatric columns. Note that 100/80/50 denotes coverage at 100% for Diagnostic and Preventive (Class I), 80% coverage for Basic Restorative (Class II), and 50% coverage for Major Restorative (Class III).

Step 2: Coinsurance Adjustment Coinsurance adjustment factors (see TABLE-1) are given for different combinations of services. Based on the plan's benefits, find the appropriate set of coinsurance adjustment factors in TABLE-1A & TABLE-1B for Pediatric and Adult benefits respectively, and enter them in the appropriate coinsurance adjustment worksheet (Exhibits 4A & 4B) and enter the results of coinsurance adjustment worksheet into the coinsurance adjustment row of the rating worksheet.

Step 3: Multiply the Adult and Pediatric starting claim cost by the appropriate coinsurance adjustment factor for each class of service. Enter the results on the line in Exhibit 1 labeled "Adjusted starting claim cost". On the line labeled "Combined claim cost" enter the sum of the Class I, Class II, and Class III adjusted starting claim costs.

Step 4: Enter the Deductible adjustment from TABLE-2. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to a deductible and that is reflected in the Pediatric starting claim costs.

Step 5: Based on the plans annual maximum benefit, enter the appropriate annual maximum adjustment factor from TABLE-3. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to an annual max and that is reflected in the Pediatric starting claim costs.

Step 6: Geographic Area Adjustment: Refer to TABLE-4, and pick the appropriate factor based on the three-digit zip code the member resides in. Enter the factor on the rating sheet.

Step 7: Annual Trend The starting claim costs were developed with a baseline date of July 1, 2012. Claim costs are expected to increase at a trend of 5.00% annually in half month increments. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$. Enter the compounded trend amount on the annual trend line on the rating worksheet. For example if the quote applies to period of January 1st, 2014 to December 31st, 2014, the trend period is from July 1st, 2012 to June 30th, 2014 (the mid-point of the rating period), or 48 half months.

Step 8: For benefit plan designs that include waiting periods for certain benefit categories, the appropriate factor in TABLE-5 will be entered in the columns on the line labeled "Benefit Waiting Period factor". For Pediatric plans, the factor is 1.00 because the Pediatric benefits are not subject to waiting periods and that is reflected in the Pediatric starting claim costs.

Step 9: Reimbursement Factor: Refer to TABLE-6, and pick the appropriate factor based on the member's three-digit zip code and enter it on the rating sheet. The same factor will be used in the in the participating provider columns and the non-participating provider columns for both Pediatric and Adult plans.

Step 10: Provider Usage Factor: Refer to TABLE-7, and enter the provider usage factors in the appropriate columns.

Step 11: Out-of-Pocket Maximum Factor: The Pediatric dental benefit has an annual Out-of-Pocket Maximum of $700 for an individual up to a limit of $1,400 for the family priced into the Pediatric dental product and has a factor of 1.00 in the rating worksheet. If a $1,000 Out-of-Pocket Maximum for an individual up to a limit of $2,000 for the family members up to the age of 19 is used, a factor of .975 is used for the Out-of-Pocket Maximum factor line in the Pediatric columns in the rating worksheet.

Step 12: Family Factor: Enter the appropriate Family Factor from TABLE-8 depending on the product that is purchased. For purchasers of an Anthem Dental Family product, the Family Factor is to account for administrative efficiencies and decreased anti-selection risk of a family purchasing instead of individual purchasers of separate Pediatric and Adult policies.

Step 13: On the line labeled "Total Claim Cost", enter the product of multiplying the combined claim cost from step 3 by the factors in steps 4 through 12.

Step 14: Retention: Enter 1 minus the retention amount from TABLE-9. The expected loss ratio for this product is 70.54% for Off-Exchange.

Step 15: On the line labeled "Gross Monthly Premium": enter the result of dividing the amount from step 13 by the amount in step 14.

Step 16: Blended Premium: To determine the blended premium rate, add the results from step 14, for the Participating Provider column, and the Non-Participating Provider column. Do this for both the Pediatric and Adult columns.

Step 17: Ortho Premium: The orthodontia premium is calculated in Exhibit 5. Dentally Necessary Orthodontia is included in all Pediatric plans and is the Pediatric class IV claim cost. This amount should be entered into the line 1 of Exhibit 5 under the Pediatric column. For the Anthem Dental Family Enhanced product, cosmetic orthodontia is included for members age 8 up to age 19 and the claim cost of the cosmetic orthodontia is located in TABLE-10 and entered in line 2 of Exhibit 5 in both the Pediatric and Adult columns. The sum of the costs for the Pediatric and Adult costs are entered in line 3 of Exhibit 5. In line 4 of Exhibit 4, enter 1 minus the retention percentage from TABLE-9. In Exhibit 5, line 5 equals

line 3 divided by line 4 to give the orthodontia premium amount to enter for the Orthodontia Premium in the rating worksheet.

Step 18: Final Premium Rates: Enter the sum of the Blended Premium Rate and Ortho Premium from step 16 and step 17 and enter into the Final Premium Rate for both the Pediatric and Adult columns.

Step 19: For the Anthem Dental Pediatric and Anthem Dental Adult products, the rates from step 18 are the rates to use multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. For the Anthem Dental Family products, Exhibit 3 is used to calculate the number of pediatric and adult premiums that will be rated for based on the makeup of the family, and the resulting values from Exhibit 3 are used in the Rating Worksheet for the Number of Pediatric Premiums and the Number of Adult Premiums, respectively. The Total Contract Premium is calculated by multiplying the rates in the Pediatric column from step 18 by the Number of Pediatric Premiums and adding the product of the Final Premium Rate in the Adult column from step 18 and the Number of Adult Premiums.

TABLE - 1A
Pediatric Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.1111	1.020	100%	2.000	1.050	100%	2.000	1.100
90%	1.0000	1.000	80%	1.600	1.041	50%	1.000	1.000
80%	0.8889	0.990	60%	1.200	1.010			
70%	0.7778	0.980	50%	1.000	1.000			

Default plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4A for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 1B
Adult Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.0000	1.000	90%	1.800	1.046	60%	1.200	1.030
90%	0.9000	0.993	80%	1.600	1.026	50%	1.000	1.000
80%	0.8000	0.992	60%	1.200	1.005	30%	0.600	0.965
75%	0.7500	0.988	50%	1.000	1.000	25%	0.500	0.955
50%	0.5000	0.970	30%	0.600	0.974	15%	0.300	0.945
			25%	0.500	0.964	0%	0.000	0.000
			15%	0.300	0.944			
			0%	0.000	0.000			

Default plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4B for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 2

Benefit Year Deductible Factors

	Factor
Deductible does not apply to Diagnostic and Preventive Services	1.00
Deductible does apply to Diagnostic and Preventive Services	0.95

Note:
A $50 per person deductible will apply to any Adult benefit set. The only variable regarding the deductible is whether or not the deductible applies to Diagnostic and Preventive Services. A $50 deductible applies to non-D&P services for Pediatric plans.

TABLE - 3

Annual Maximum Benefit Factors

Annual Maximum Amount	Factor
$500	0.9100
$750	0.9400
$1,000	0.9690
$1,200	1.0000
$1,250	1.0078
$1,500	1.0600
$1,750	1.0950
$2,000	1.1300
$2,500	1.2200

Note: For a quote that has D & P coverage only, annual maximum factors for all amounts equals amounts equals 1.00. Pediatric plans do not have an annual max therefore have a factor of 1.00 because the unlimted maximum is built into the starting claim cost.

TABLE - 4

Geographic Area Adjustment

Rating Area	Factor
Statewide	1.020

TABLE - 5

Benefit Waiting Period Factors

Services Covered	Factor
6 month waiting period on Basic Restorative and 12 month on non-D&P	0.975
12 month waiting period on Class III Only	1.000
Class I, Class II, and Class III are all covered with no waiting period	1.050

Note: Pediatric plans do not have waiting periods on non-orthodontia services therefore get a factor of 1.00.

TABLE - 6

Reimbursement Factors

Rating Area - Three-Digit Zips Included	Factor
Statewide	
Prime Network Reimbursement Factor	0.700
Non-Participating Reimbursement Factor	0.700

TABLE-7

Provider Usage Factors

Rating Area - Three-Digit Zips Included	**Factor**
Statewide	
Prime Network Usage Factor	0.507
Non-Participating Usage Factor	0.493

TABLE - 8

Family Factor

Product	**Factor**
Anthem Dental Pediatric Products	1.0000
Anthem Dental Adult Products	1.0000
Anthem Dental Family Products	0.9750

TABLE - 9

Retention Factor

	Retention as % of Premium	
	On-Exchange	Off-Exchange
Administration Expense	12.00%	12.00%
Premium Tax	1.00%	1.00%
ACA Insurer Fee	2.46%	2.46%
Exchange Fee	0.00%	0.00%
Commission	8.00%	8.00%
Profit / Risk Charge	6.00%	6.00%
Retention	**29.46%**	**29.46%**

TABLE - 10

Orthodontia Claim Costs

Orthodontia Benefit	**Claim Cost**
Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.36
Cosmetic Orthodontia per member per month cost $1,000 Lifetime Maximum with 12 Month Waiting Period Costemic Orthodontia is all orthodontia cases not deemed Dentally Necessary Orthodontia	$3.65
Dentally Necessary with no cost share for AV calculation Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.54

Exhibit 1 -- Individual Dental Rating Worksheet

Name	Product
Location (Zip Code)	Effective Date

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1												
Adjusted starting claim cost		Product of above 2 lines												
Combined Claim Cost		Sum of the 3 Classes												
Deductible adjustment		Refer to TABLE-2												
Annual maximum adjustment		Refer to TABLE-3												
Geographic area adjustment		Refer to TABLE-4												
Annual trend		Refer to Step 7												
Benefit waiting period factor		Refer to TABLE-5												
Reimbursement factor		Refer to TABLE-6												
Provider Usage factor		Refer to TABLE-10												
Out-Of-Pocket Max Factor		Refer to Step 11												
Family Factor		Refer to TABLE-8												
Total Claim Cost		Product of Combined Claims Cost factors and adjustments												
Retention	29.46%	Refer to TABLE-9	70.54%			70.54%			70.54%			70.54%		
Gross Monthly Premium		Total claim cost divided by (1 - Retention)	$0.00			$0.00			$0.00			$0.00		

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program		
Non-Participating Program		
Total	**$0.00**	**$0.00**

Ortho Premium	Refer to Exhibit 4 and Step 17	Pediatric	Adult
Total			

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total			

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total				**$0.00**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name	J. Doe
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6500	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.0200	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-10		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 4 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 3 -- Anthem Dental Family Product -- Number of Rates Worksheet

Name	J. Doe
Product	Anthem Dental Family Enhanced

Number of members in family	6
Number of non-child members (a)	2
Number of child members age 19 and older (b)	2
Number of child members under age 19 (c)	2

Number of non-child members to be rated (d):	2
Take the number (a)	
Number of children age 19 and older to be rated (e):	2
Take the lesser of (b) and 3	
Number of children age under age 19 to be rated (f)	1
Take the lesser of 3 minus (d) or (c)	

Number number of adult premiums rated	**4**
Take the sum of (d) and (e)	
Number of pediatric premiums to be rated for (f)	**1**

Exhibit 4A -- Pediatric Dental Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	90	50	50	50
3 Claim Impact Factors (Table-1)	1.111	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0200	1.0410	1.0000	1.0000
5 Total Change	1.1333	1.6656	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.6260	0.3740	1.0000
7 Total Weighted Change	1.1333	1.0427	0.3740	1.0000
8 Coinsurance Factor for Exhibit1	1.1333	1.4167		1.0000

Baseline plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 4B -- Adult Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	100	50	50	50
3 Claim Impact Factors (Table-1)	1.000	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0000	1.0260	1.0000	1.0000
5 Total Change	1.0000	1.6416	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.5283	0.4717	1.0000
7 Total Weighted Change	1.0000	0.8673	0.4717	1.0000
8 Coinsurance Factor for Exhibit1	1.0000	1.3390		1.0000

Baseline plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 5 -- Orthodontia Premium Worksheet		
Product		
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)		
Cosmetic Orthodontia (line 2)		
Total Orthodontia Claim Cost (line 3)		
Retention (line 4)		
Orthodontia Premium (line 5)		

Exhibit 6 -- Orthodontia Premium Worksheet -- Sample Calculation		
Product	Anthem Dental Family Enhanced	
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)	$0.39	$0.00
Cosmetic Orthodontia (line 2)	$3.65	$3.65
Total Orthodontia Claim Cost (line 3)	4.04	3.65
Retention (line 4)	70.54%	70.54%
Orthodontia Premium (line 5)	5.73	5.17

Exhibit 7

Development and Justification for Administrative Expense Load and Commission Load

Colorado Prime Network Products

These Prime Network dental products are administered by DeCare Dental which is a wholly owned subsidiary of WellPoint Inc. Anthem Blue Cross Blue Shield of Colorado is also a subsidiary of WellPoint Inc.

ADMINISTRATIVE EXPENSE

(a)	DeCare Dental administers a large block of small group dental risk products. Total incurred costs for administrative expenses for 2010 for the small group dental risk business administered by DeCare dental was:	$19,279,150
(b)	Total earned premium for 2010 for the small group dental risk business administered by DeCare Dental and mentioned in (a) above was:	$126,399,305
(c)	Incurred administrative costs as a percent of earned premium for 2010 for DeCare Dental's small group dental risk business was (a)/(b) which equals:	15.25%
(d)	Average annual premium per member per month (PMPM) for the small group dental business administered by DeCare Dental:	$24.43
(e)	Average monthly premium per member per month (PMPM) for the HCR compliant Prime Network business expected in Colorado:	$30.87
(f)	Ratio of average premium PMPM for DeCare small group business to expected average PMPM premium for Colorado Prime Network HCR business, equals (d) / (e):	0.791
(g)	Since the average expected Colorado dental premium is greater than the average DeCare small group dental premium, a lower percent of premium is needed to generate the needed administrative expense to operate the CO small group Prime % Complete business. That percentage is equal to (f) x (c) which equals:	12.07%

Anthem Blue Cross Blue Shield (BCBS) of Colorado does have a block of small group dental risk business. Below is some data regarding that business.

COMMISSION EXPENSE

(a)	Earned premium for 2012 for Anthem BCBS of Colorado small group dental business:	$5,229,195
(b)	Incurred commissions for 2012 for Anthem BCBS small group dental business:	$550,514
(c)	Ratio of commissions to premium for 2012 for Anthem BCBS small group dental	10.53%

(d) The 10.53% commission percentage above is a result of the commissions that were paid for Anthem BCBS's small group dental business in 2012. Generally most of the products have a 10% commission for the writing agent, and there are a few agreements in place in which a managing general agent receives a commission override. So, the commission in (c) above is made up of a 10% writing agent commission and a .43% commission override.
For the new Prime Network dental products, some of the sales will be made directly by the consumer without any compensation paid to a broker or a navigator, thereby having no commission expense. With this in mind, we are expecting an average commission rate for these HCR compliant products to be sold on and off exchange to be 8%.

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Supporting Document Schedules

Satisfied - Item:	HR-1 Form (H)
Comments:	
Attachment(s):	HR-1 SG v2.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	Actuarial Memorandum for OFF Exchange v2.pdf Actuarial Memorandum for ON Exchange v2.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter
Comments:	
Attachment(s):	Cover Letter SG.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Crosswalk
Comments:	
Attachment(s):	Crosswalk for Ids.xlsx
Item Status:	
Status Date:	

SERFF Tracking #:	ANTV-129075587	**State Tracking #:**	278985	**Company Tracking #:**	

State:	Colorado	**Filing Company:**	Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	Anthem Dental Pediatric Adult Family Enhanced SG Rates		
Project Name/Number:	/		

Attachment Crosswalk for Ids.xlsx is not a PDF document and cannot be reproduced here.

State Of Colorado

Health Rate Filing Form

Form HR-1

Reset Form

Must Be Completed For All Products SERFF FILING # ANTV-129075587

1. Company: Rocky Mountain Hospital and Medical Services, Inc., dba Anthem Blue Cross and E

2. Person Responsible For Filing: Robert L. Mikkelsen	3. Title: Actuarial Director
4. Address Of Responsible Person: 3560 Delta Dental D	5. Telephone #: (651) 406-5983 ext.

6. Email Address: robert.mikkelsen@wellpoint.com

7. **Type Of Coverage**: PPO Other :

8. Medicare Supplement: N/A Not Applicable ☑

(1) Prestandardized Plan(s):

(2) Standardized Plan(s): ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ FHD ☐ G ☐ H ☐ I ☐ J ☐ JHD ☐ K ☐ L

(3) 2010 Plans: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ FHD ☐ G ☐ K ☐ L ☐ M ☐ N

9. **Sub Category:** Small Group (1-50)

10. A. Group Information: Employer N/A N/A N/A

B. Name of association or trust *(if applicable)*:

C. Description of discretionary group*(if applicable)*:

11. **Colorado State Code(s)**: 701 Small Group N/A

N/A N/A N/A

12. **Brief Filing Description** (Disability, Major Medical, LTC, Etc. Also Describe All Methodology Changes.):

Small Group Dental PPO Product

13. **Reason For Filing:**	
Increase In Benefits?	☐ Yes ☑ No
Reduction In Benefits?	☐ Yes ☑ No
Increase in Profits?	☐ Yes ☑ No
Change Needed To Meet Projected Losses?	☐ Yes ☑ No
Trend Only?	☐ Yes ☑ No
Change In Rating Methodology?	☐ Yes ☑ No
New Product (Initial Offering As Opposed To Rate Revision)?	☑ Yes ☐ No
Other?	☐ Yes ☑ No
(If other, please explain)	

14. **Policy Form(s) Affected**: 13-03271.06-SG, 13-03271.06-SG-EX

15. If Rider Or Endorsement, **Type Of Benefits**? N/A

16. Closed Block(s)? ☐ Yes ☑ No Date Block Closed:

17. **Number Of Colorado Covered Lives** (Including Employees And Dependents): N/A

18. A. Rating Period: Annual From 1/1/2014 To 1/1/2014
B. Experience Period: From To
C. Reason for Rate Change:
D. Average Change In Rates From One Year Prior To Effective Date: 0.00%

☑ N/A (New Product)

19. A. **Rate Change Without Trend:** 0.00%
B. **Trend for Rating Period (if trend factor is used in rates):** 0.00%
C. Overall Rate Impact Change: 0.00%

20. A. **Current Underlying *Annualized* Trend Assumption** (If Applicable): 0.00%
B. Requested Underlying *Annualized* Trend Assumption (If Applicable): 0.00%

21. A. **What Is The Maximum Rate Change That Can Affect A Policyholder?** 0.00%
B. **What Is The Minimum Rate Change That Can Affect A Policyholder?** 0.00%

(If the selected rate change differs from the indicated rate change, please fully detail in the actuarial memorandum in section 6K.)

Benefits Ratios (**On Colorado only basis**)

22. A. Targeted Benefits Ratio over Rating Period (assumed in calculation of rates): 70.54%

B. Actual Benefits Ratio over Experience Period: 0.00%

☑ N/A (New Product)

23. A. **Projected Benefits Ratio With Rate Change over Rating Period** 0.00%
B. Projected Benefits Ratio **Without** Rate Change over Rating Period 0.00%

☐ Colorado
☐ Colorado/Nationwide
☐ Nationwide Basis

☑ N/A (New Product)

(If projected benefits ratios on a Colorado only basis are not available, then ratios developed on a blended Colorado/Nationwide or Nationwide basis are acceptable. Please indicate above.)

24. **Proposed Effective Date:** 01/01/2014

25. A. **Total Annual *Colorado* Written Premium Before Change(s)**: $
B. **Total Annual *Colorado* Written Premium After Change(s)**: $
C. Written Premium Change For This Product (Net Change): $

☑ N/A (New Product)

26. A. **Effective Date** of Previous Rate Filing for this Form (including initial filing):
B. Previous SERFF Filing Number(s):
C. Overall Percentage of Last Rate Change for Affected Policy Forms: 0.00%

☑ N/A (New Product)

27. **Experience Provided:** ☐ **Nationwide** ☐ **Colorado** Select One
☐ **other (specify)**

☑ N/A (New Product)

28. ***Small Group Filings Only*: Unique Single Index Rate** **(Effective For All Small Group Plans):**

When completed, please hit the button to the right and also attach to filing in SERFF. **SUBMIT TO DIVISION**

Rocky Mountain Hospital and Medical Services, Inc.
Actuarial Memorandum
Anthem Dental Rate Manual

A. Summary

Reason(s) for the rate filing
This is a new rate filing.

Requested Rate Action
No rate action requested as this is a new rate filing and there is no historical data.

Marketing method(s)
This product will be marketed and sold Off Exchange by licensed brokers, via the internet and direct response to groups and individuals and their families residing in Colorado. It will be administered by DeCare Dental which is a licensed dental administrator.

Premium classification
Premiums for this product will vary by the following criteria: Benefits covered (coinsurance amounts, annual maximum benefits on adult benefits, deductibles, etc), age of the member which dictates the type of benefits available.

Product descriptions
This dental contract provides a variety of dental benefits that can be provided by an Anthem contracted provider, or a non-contracted provider. A detailed description of the benefit options may be found in the contract filing. In addition, a brief summary of the dental benefits is provided on page 2 of the rate manual portion of this rate filing.

Policy/Rider form
The memorandum address the following policy/rider forms

- Small Group policies: 13-03271.06-SG
- Individual policies: 13-03281.06-IND

Age basis
Members with an issue age below 19 will receive pediatric premiums associated with those benefits. Members with an issue age 19 and older will receive adult premiums associated with those benefits. All renewals will use the renewal age to set premiums.

Renewability provision
This product is guaranteed renewable.

B. Assumption, Acquisition or Merger

The product in this rate filing was not part of an assumption, acquisition, or merger with another company.

C. Rating Period

The rating period for this product and rate filing covers a one year period. The effective date, or the starting date, will be January 1, 2014, and the end date will be one year after the effective date. In addition, the effective date will not be before the approval date of this rate filing by the Colorado Department of Insurance.

D. Underwriting

The insured's application denotes the selected product, and effective date of coverage. An insured that cancels the Anthem dental plan cannot re-enroll for two years.

E. Effect of Law Changes

Not Applicable

F. Rate History

This is a new product and a new rate filing, therefore there is no prior rate history.

G. Coordination of Benefits

All coordination of benefit savings has been reflected in the baseline starting claims cost.

H. Relation of Benefits to Premium

The premiums are determined by developing the claims costs based on benefit design and group or individual's demographics and then dividing that number by the 1 minus the retention. TABLE-9 (given below) details each specific component of the retention load. These expenses are based on anticipated needs of Colorado-specific business. The anticipated retention is 29.46% and therefore the loss ratio is 70.54% which is well above the minimum of 60% set forth in CO regulation 4-24-11, section 6.H.3.b.

Retention Components	**Off-Exchange**	**Explanation**
Administration Expense	12.00%	*See Exhibit 7
Premium Tax	1.00%	CO Statute
ACA Insurer Fee	2.46%	Federal Fee
Exchange Fee	0.00%	0 cost
Commission	8.00%	*See Exhibit 7
Profit / Contingency	6.00%	*See Section J
Retention	**29.46%**	

I. Lifetime Loss Ratio

The products included in this rate filing were not priced using a lifetime loss ratio standard.

J. Provision for Profit and Contingencies

The Provision for Profit and Contingencies is set at 6% - below the 7% maximum outlined in CO regulation 4-24-11, section 6.J. This 6% is factored into retention to allow for accumulation of fund surplus and reserves necessary for Anthem BCBS to have adequate funds on hand to provide for unexpected claim volatility and fluctuations.

K. Complete Explanation as to How the Proposed Rates were Determined

Please refer to the the Dental Rate Manual that is attached to this memorandum

L. Trend

The starting claim costs were developed for an effective mid-point date of July 1st, 2012. The trend formula is (1 + (trend %/100))^ ((mid-point of rating period – July 1, 2012 expressed in integer half months)/24). Starting July 1st, 2012, claim costs are expected to increase at a trend of 5.00% annually in half-month increments. Premium rates will be guaranteed for 12 months, but for purposes of new sales, will change annually using the middle of the rating period to calculate the trend amount. For example, the January 1st, 2014 to December 31st, 2014 uses a rating period midpoint of June 30th, 2014 in calculating the trend amount.

The 5% projected trend assumption is composed of the following 3 components

- Utilization: 1.5% increase in services per exposure because of the expectation that the influx of previously uninsured will utilize more than the average person in year 1
- Unit cost: 2.0% increase in allowed charges from dental providers because the dental CPI is forecasted to increase more than 3% due to economic improvements and pent up demand to increase prices – this will mostly impact the non-participating provider
- Service Mix: 1.5% increase due to influx of the uninsured that will need more intense (Basic) services than the average policyholders.

Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. The membership steadily grew until 2013 and is starting to level off. As a result of the changing membership, the claim trends do not increase as one would expect because the new membership are selecting plans that have benefits that are less rich. As noted above, we do expect that the membership for Anthem Dental Adult / Pediatric will likely have a lot of pent up demand.

Table L.1

Statistics by Incurred Year

Year	Period	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Net Trend
2010	Starts Apr	4,692	9,009	$241,048	$241,048	$0	1,330	n/a
2011	CY	20,830	40,269	$896,589	$896,589	$0	5,268	-16.8%
2012	CY	38,783	74,929	$1,560,407	$1,556,209	$4,198	9,535	-6.5%
2013	YTD June	22,268	42,983	$863,043	$794,465	$68,577	4,949	-3.6%
All	Total	**86,573**	**167,190**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	

Table L.2

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Month

Year	Month	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts
2010	1	0	0	$0	$0	$0	0
2010	2	0	0	$0	$0	$0	0
2010	3	0	0	$0	$0	$0	0
2010	4	64	148	$4,117	$4,117	$0	22
2010	5	242	448	$11,792	$11,792	$0	60
2010	6	298	556	$12,270	$12,270	$0	76
2010	7	399	743	$19,910	$19,910	$0	116
2010	8	474	905	$22,930	$22,930	$0	134
2010	9	592	1,147	$27,856	$27,856	$0	167
2010	10	730	1,437	$37,886	$37,886	$0	202
2010	11	849	1,655	$43,918	$43,918	$0	234
2010	12	1,044	1,970	$60,369	$60,369	$0	319
2011	1	1,314	2,560	$49,817	$49,817	$0	293
2011	2	1,431	2,799	$57,388	$57,388	$0	357
2011	3	1,517	2,965	$75,785	$75,785	$0	440
2011	4	1,566	3,035	$65,564	$65,564	$0	382
2011	5	1,639	3,158	$76,557	$76,557	$0	442
2011	6	1,654	3,202	$78,525	$78,525	$0	468
2011	7	1,729	3,375	$81,911	$81,911	$0	450
2011	8	1,820	3,532	$93,680	$93,680	$0	557
2011	9	1,882	3,622	$63,690	$63,690	$0	386
2011	10	1,972	3,768	$71,239	$71,239	$0	431
2011	11	2,063	3,962	$80,260	$80,260	$0	480
2011	12	2,243	4,291	$102,173	$102,173	$0	582
2012	1	2,699	5,185	$122,698	$122,666	$32	688
2012	2	2,810	5,419	$112,787	$112,751	$36	701
2012	3	2,892	5,608	$116,880	$116,834	$46	731
2012	4	2,961	5,743	$115,993	$115,924	$70	711
2012	5	3,016	5,832	$113,131	$113,040	$91	746
2012	6	3,092	5,978	$123,423	$123,278	$145	777
2012	7	3,275	6,351	$127,931	$127,724	$207	769
2012	8	3,386	6,557	$148,147	$147,819	$328	908
2012	9	3,437	6,637	$129,136	$128,724	$412	823
2012	10	3,614	6,952	$146,397	$145,760	$637	915
2012	11	3,717	7,154	$152,312	$151,388	$924	899
2012	12	3,884	7,513	$151,572	$150,302	$1,270	867
2013	1	3,869	7,461	$171,506	$169,501	$2,005	979
2013	2	3,849	7,392	$143,835	$141,496	$2,338	828
2013	3	3,785	7,266	$142,227	$138,727	$3,499	897
2013	4	3,786	7,294	$145,004	$138,480	$6,523	871
2013	5	3,583	6,982	$133,282	$122,013	$11,269	782
2013	6	3,396	6,588	$127,189	$84,248	$42,941	592

M. Credibility

This product is new and thus does not have any experience. So, we used a similar product's information displayed in section N. This data is fully credible since there are more than 2,000 life years (24,000 members months) and 2,000 claims –totals are in Table N.1 in Section N.

N. Data Requirements

This is a new product and thus there are no earned premiums, incurred claims, actual benefits ratios, number of claims, average covered lives and number of policyholders to submit on a Colorado-only basis for at least 3 years. Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. Below is the yearly summary.

Table N.1

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Year

													Average	
Year	Period	Subscriber Months	Member Months	Billed Premium	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Loss Ratio	Premium PMPM	Incurred PMPM	Net Trend	Subscribers	Members
2010	Starts Apr	4,692	9,009	$294,677	$241,048	$241,048	$0	1,330	82%	$32.71	$26.76	n/a	616	1,183
2011	CY	20,830	40,269	$1,288,819	$896,589	$896,589	$0	5,268	70%	$32.01	$22.26	-16.8%	1,872	3,608
2012	CY	38,783	74,929	$2,428,330	$1,560,407	$1,556,209	$4,198	9,535	64%	$32.41	$20.83	-6.5%	3,424	6,614
2013	YTD June	22,268	42,983	$1,389,503	$863,043	$794,465	$68,577	4,949	62%	$32.33	$20.08	-3.6%	3,636	7,031
All	Total	**86,573**	**167,190**	**$5,401,329**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	**66%**	**$32.31**	**$21.30**			

O. Side-by-Side Comparison

This is a new product and thus there is nothing that can be compared.

P. Benefits Ratio Projections

The following is the 2014 projection of incurred claims, revenue and benefit loss ratios. Note that this is a new filing and there is no rate change request –that's why there are zeroes in the "Without Change" section.

Table P.1

	With Change			Without Change		
Date	**Prem**	**Clms**	**LR**	**Prem**	**Clms**	**LR**
1/1/2014	$459,985	$335,581	73%	$0	$0	n/a
2/1/2014	$633,483	$396,456	63%	$0	$0	n/a
3/1/2014	$797,830	$526,635	66%	$0	$0	n/a
4/1/2014	$825,590	$557,156	67%	$0	$0	n/a
5/1/2014	$822,762	$525,419	64%	$0	$0	n/a
6/1/2014	$820,104	$540,782	66%	$0	$0	n/a
7/1/2014	$821,525	$543,676	66%	$0	$0	n/a
8/1/2014	$819,824	$524,673	64%	$0	$0	n/a
9/1/2014	$819,182	$495,312	60%	$0	$0	n/a
10/1/2014	$820,334	$526,982	64%	$0	$0	n/a
11/1/2014	$818,546	$460,460	56%	$0	$0	n/a
12/1/2014	$843,376	$622,756	74%	$0	$0	n/a

Q. Other Factors

Please refer to the information below and the Dental Rate Manual that is attached to this memorandum.

Proposed Premium Rates PMPM

The rates to use (in Table Q.1) multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. The propose premium rates are on per member per month (PMPM) basis.

Table Q.1

		Premium PMPM			
		70 % AV		85% AV	
CO Product IDs	Description of Product	Adult	Pediatric	Adult	Pediatric
87269CO113	SG PPO Pediatric Dental Off Exchange		$17.90		$20.92
87269CO114	SG PPO Adult Dental Off Exchange	$24.93		$33.17	
87269CO115	SG PPO Family Dental Off Exchange	$24.31	$17.46	$37.52	$25.58
87269CO116	Individual PPO Pediatric Dental Off Exchange		$17.90		$20.92
87269CO117	Individual PPO Adult Dental Off Exchange	$24.93		$33.17	
87269CO118	Individual PPO Family Dental Off Exchange	$24.31	$17.46	$37.52	$25.58

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Family Low Plan Off-Exchange	87269CO1180001
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000	1.0000	1.0000	1.0000	0.4850	0.4820	0.4775
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17	$19.29	$11.79	$8.25	$9.36	$5.68	$3.94
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00			$39.33			$18.98	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9400			0.9400	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.66			$5.30			$13.67			$6.41	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.44			$7.51			$19.37			$9.09	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$9.44	$19.37
Non-Participating Program	$7.51	$9.09
Total	**$16.95**	**$28.46**

Ortho Premium (Refer to Exhibit 5 and Step 17)	Pediatric	Adult
Total	**$0.51**	**$0.00**

Final Premium Rate (Refer to Step 18)	Pediatric	Adult
Total	**$17.46**	**$28.46**

Final Total Premium Rate (Refer to Step 19)	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total	**1**	**4**	**$131.30**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Pediatric Low Plan Off-Exchang	87269CO1160001
Location (Zip Code) 81612	

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.83			$5.44	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.69			$7.70	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$9.69
Non-Participating Program	$7.70
Total	**$17.39**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric
Total		**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$17.90**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Family High Plan Off-Exchang	87269CO1180002
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6499	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 5 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Pediatric High Plan Off-Exchang	87269CO1160002	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$8.17			$6.23	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.58			$8.83	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$11.58
Non-Participating Program	$8.83
Total	**$20.41**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric
Total		**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$20.92**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Family Low Plan Off-Exchange-	87269CO1150001	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000	1.0000	1.0000	1.0000	0.4850	0.4820	0.4775
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17	$19.29	$11.79	$8.25	$9.36	$5.68	$3.94
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00			$39.33			$18.98	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9400			0.9400	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.66			$5.30			$13.67			$6.41	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.44			$7.51			$19.37			$9.09	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$9.44	$19.37
Non-Participating Program	$7.51	$9.09
Total	**$16.95**	**$28.46**

Ortho Premium (Refer to Exhibit 5 and Step 17)	Pediatric	Adult
Total	**$0.51**	**$0.00**

Final Premium Rate (Refer to Step 18)	Pediatric	Adult
Total	**$17.46**	**$28.46**

Final Total Premium Rate (Refer to Step 19)	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total	**1**	**4**	**$131.30**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Pediatric Low Plan Off-Exchange-	87269CO1130001
Location (Zip Code) 81612	

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.83			$5.44	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.69			$7.70	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$9.69
Non-Participating Program	$7.70
Total	**$17.39**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric
Total		**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$17.90**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Family High Plan Off-Exchange-	87269CO1150002
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6499	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium (Refer to Exhibit 5 and Step 17)	Pediatric	Adult
Total	**$5.68**	**$5.17**

Final Premium Rate (Refer to Step 18)	Pediatric	Adult
Total	**$25.58**	**$37.52**

Final Total Premium Rate (Refer to Step 19)	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total	**1**	**4**	**$175.66**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Pediatric High Plan Off-Exchange-	87269CO1130002	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$8.17			$6.23	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.58			$8.83	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$11.58
Non-Participating Program	$8.83
Total	**$20.41**

Ortho Premium	Refer to Exhibit 5 and	Pediatric
Total	Step 17	**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$20.92**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

The purpose of this filing is to demonstrate compliance with minimum requirements of the state of Colorado and show that the benefits are reasonable in relation to premiums charged.

This Anthem Blue Cross and Blue Shield (Anthem BCBS) Anthem Dental Rate Manual applies to the Anthem Dental Pediatric/Adult/Family products which are HCR compliant. This rate manual applies to rates that are being used and developed on behalf of Rocky Mountain Hospital and Medical Services, Inc, also doing business as Anthem BCBS. This rate manual applies to Small Group policies 13-03271.06-SG, Individual policies and 13-03281.06-IND. Individuals will be able to select plans with a range of benefit design options. This rate manual and the rates developed by it will be effective January 1st, 2014.

The rating method begins with starting claim costs. Factors are then applied to these costs that develop rates based on the member's benefit plan. The methodology will use linear interpolation to derive the appropriate factors for benefits not explicitly stated in this rate manual. The rating steps are shown in the two rating worksheets in the back of the Anthem BCBS Anthem Dental Rate Manual. Exhibit 1 shows the rating worksheet template, and Exhibit 2 shows a sample rate calculation.

Definitions

Class of Dental Services
Class I – Diagnostic and Preventive
Class II – Basic services; simple restorations, periodontics, endodontics and oral surgery
Class III – Major restorative services; prosthodontics and prosthetics
Class IV – Orthodontics; Dentally Necessary Orthodontics

Pediatric – Pediatric EHB Mandated Dental Benefits for individuals up to the age of 19
Adult – Dental Benefits for individuals age 19 and over
Family – Pediatric and Adult benefits purchased as a single contract. Individuals up to the age of 19 receive Pediatric benefits and individuals age 19 and over receive Adult benefits.
AV – Actuarial Value measured using benefits when using a participating provider represents the percentage of costs covered by the plan

Plan Offerings

Anthem Dental Pediatric Plan – Pediatric dental benefit with 70% AV
Anthem Dental Pediatric Enhanced Plan – Pediatric dental benefit with 85% AV
Anthem Dental Adult Plan – Adult dental benefit
Anthem Dental Adult Enhanced Plan – Adult dental benefit with higher coinsurance levels
Anthem Dental Family Plan – A combination of Anthem Dental Pediatric Plan and Anthem Dental Adult Plan with benefits based on the age of family members
Anthem Dental Family Enhanced Plan – A combination of Anthem Dental Pediatric Enhanced Plan and Anthem Dental Adult Enhanced Plan with benefits based on the age of family members; includes cosmetic orthodontia for children from age 8 up to age 19

Morbidity

The starting claim cost for each class of service (Diagnostic & Preventive, Basic, Major, and Orthodontics) is based on analyses of several recent years of claim data. An extensive claim database was used to derive this experience. This data is supplemented as needed by data provided by Milliman USA, an Actuarial Consulting firm.

Analyses were conducted separately for each of the following services: diagnostic and preventive, basic restorative, periodontic, endodontic, oral surgery, major restorative, prosthodontics, prosthetic repairs and orthodontics. The results were then aggregated into Class I, Class II, Class III and Class IV services.

The starting claim costs are developed assuming reimbursement at the full amount of the dentist submitted charge, where the dentist submitted charge is equal to a national average. The starting claim costs experience has a midpoint date of July 1, 2012.

The monthly starting Pediatric and Adult benefit claim costs are:

	Pediatric	Adult
Class I Diagnostic and Preventive Services	$13.10	$19.29
Class II Basic Services	$ 3.85	$11.79
Class III Major Services	$ 0.17	$ 8.25
Class IV Orthodontic Services	$ 0.39	$ 0.00

The Adult plans starting claim costs assume coinsurance levels of 100% for Class I services, 50% for Class II services, 50% for Class III services, a $50 per person deductible and a $1,200 annual maximum. The specific procedures defined by the PPACA Stand-Alone Dental Plan Procedures for Colorado dated May 31, 2013 are the only procedures covered in the Pediatric starting claim costs. The Pediatric starting claim costs assume coinsurance levels of 90% for Class I services, 50% for Class II services, 50% for Class III services, and also include Class IV Orthodontic Services as Dentally Necessary Orthodontia assuming a coinsurance level of 50%. All Pediatric plan starting claim costs assume no annual maximum and an out-of-pocket maximum of $700 per member up to a maximum of $1,400 per family. The pediatric plans also include a $50 deductible for non-Diagnostic & Preventive services which is included in the starting claim costs. TABLE-1 (see Rate Manual for Tables TABLE-1 through TABLE-10 referenced in this Actuarial Memorandum) lists the coinsurance percentages being offered and their corresponding adjustment factors for each of the three classes of services to reflect the differences from the coinsurance levels used to establish the starting claim costs. Due to the out-of-pocket maximum on the pediatric benefit, Class IV claim costs will not change with varying coinsurance.

Pediatric EHB Actuarial Value

The model used to develop the Actuarial Value (AV) for the pediatric EHB plans was comprised of dental claims data of members under the age of 19. The data was used to develop annual utilization by procedure code for all covered services under the pediatric EHB while including utilization adjustments for non-traditional benefits such as no annual max and an annual out-of-pocket maximum. Average allowed amounts by procedure were used to establish a total claim costs by benefit category for In-Network claims. Coinsurance levels where then determined by benefit category, defined as Class I through Class V in the preceding paragraph, and the ratio of the resulting claim costs with coinsurance to the total

claim costs with 100% coverage is then verified to be within the AV of 70% plus or minus 2% or 85% plus or minus 2%.

Actuarial Value Calculation

The Actuarial Value (AV) calculation is determined as the ratio of the EHB claim costs of a certain benefit set in comparison to the claim costs of 100% coverage of the same benefits for In Network providers. The starting claim costs are adjusted for necessary coinsurance adjustments by pediatric benefit class using Table 1A. The table below shows the AV calculation for the Anthem Dental Pediatric Plans.

Benefit Class	Starting Claim Cost	Anthem Dental Pediatric	Anthem Dental Pediatric Enhanced	100% Coverage w/no deductible
Class I	$13.10	$13.10	$14.85	$15.31
Class II	$3.85	$3.85	$5.45	$8.34
Class III	$0.17	$0.17	$0.17	$0.39
Class IV	$0.36	$0.36	$0.36	$0.54
Total Claim Cost	$17.48	$17.48	$20.83	$24.57
Actuarial Value		**71.2%**	**84.8%**	

Mortality

Not Applicable

Persistency

Not Applicable

Premium Modalization Rules

Not Applicable

Claim Liability and Reserves

Incurred but not paid (IBNP) reserves which includes an amount for claim amounts reported but not yet paid will be established using a lag factor approach. This method uses claim payment histories to estimate the amount of claims that have been incurred in a particular time period. From the incurred amount, the actual paid amount is subtracted to get the IBNP reserve.

Active Life Reserves

Not Applicable, there are no active life reserves for this product.

Coinsurance Adjustment

Coinsurance amounts may be equal for benefits provided by participating providers, or they may differ depending on whether the member gets services from a participating or a non-participating provider. Additionally, coinsurance amounts may differ between Pediatric and Adult plans. To determine the coinsurance adjustment factors that apply to a given product option, refer to TABLE-1.

Deductible Adjustment

Deductibles, if present, are $50 per person per benefit year. Deductible factors are applied to Adult plan claim costs. The benefit year deductible can either apply to diagnostic and preventive services, or it can be waived for diagnostic and preventive services. Factors for the two deductible options are found in TABLE-2. Pediatric plans are subject to a $50 deductible on non-Class I services.

Annual Maximum Adjustment

The annual maximum for each person can be between $500 and $2,000 per benefit year. Adjustment factors are shown in TABLE-3. Pediatric benefits do not have an annual maximum amount on participating provider benefits and a $1,000 annual max on non-participating provider benefits which is reflective in the Pediatric starting claim costs.

Dependent Age Adjustment

Dependents are children of the individual. All product options assume that children of enrolled individuals are covered up to age 26, regardless if they are a student or not.
If the dependent child is under the age of 19, they will have a Pediatric EHB dental benefit plan design. If the dependent child is between the ages of 19 up to age 26, they will receive an Adult dental benefit plan design. Dependent coverage up to age 26 is assumed in the starting claims cost, so no claim factors are needed for this pricing assumption.

Geographic Area Adjustment

Anthem BCBS only markets to individuals who reside in the state of Colorado. This rating model does not use different geographic areas within Colorado, therefore the rates developed in this model are used for the entire state of Colorado. Given that rates apply to the entire state, one geographic area adjustment factor is used for all rates.
The Geographic Area Adjustment varies by rating area and is in TABLE-4.

Occupational Adjustment

An occupational adjustment factor is not used in this rating model.

Prior Coverage

These Anthem Dental products may have waiting periods for Class II and Class III services for Adult plans, as discussed below. In some circumstances, if the individual purchaser has had prior comparable coverage, waiting periods will be waived. However, prior coverage is not a pricing variable used in the pricing model. There is no waiting period for Pediatric EHB benefits.

Benefit waiting period factor

Certain Adult plans may have waiting periods before certain categories of services will be covered under the plan. These waiting periods can apply to basic services, major services. If applicable, the waiting period for basic services will be 6 months, and the waiting period for major services will be 12 months. For purposes of waiting periods, Endodontic, Periodontic, and Oral Surgery services are included in major services and have a 12 month waiting period.

The Pediatric EHB benefit does not have any waiting periods on services other than dentally necessary orthodontia, which has a 12 month waiting period which is figured into the orthodontia starting claim cost. The appropriate adjustment for claims cost can be found in TABLE-5.

Reimbursement

The assumed level of provider reimbursement in the starting claims cost is set at the average of national dental submitted charges. The allowed reimbursement for the Anthem Dental Pediatric/Adult/Family products are the same whether or not the member sees a participating provider or a non-participating provider. The reimbursement adjustment factors for the Anthem Dental Pediatric/Adult/Family products are found in TABLE-6.

Orthodontia

Dentally necessary orthodontia is part of the Pediatric EHB benefit. When a non-participating provider is used, there is a $1,000 Lifetime Maximum benefit. There is no Lifetime Maximum benefit when a participating provider is used. Supplemental cosmetic child orthodontia is included for family purchasers that select the Anthem Dental Family Enhanced Plan for child dependents age 8 up to age 19.

Retention

Retention is a percentage of gross premiums and includes administrative expense, profit and Contingency, and premium tax as required. The retention table is shown in TABLE-9. The retention also includes provision for a writing agent commission as well as a commission override if applicable. The retention breakout differs between products sold Off-Exchange, however the total retention is equivalent to achieve the same price as shown in TABLE-9.

Expected Loss Ratio

The expected loss ratio for this product is 70.54%. This equals 100% less the retention percentage.

Premium

The Anthem Dental Rating Worksheet (Exhibit 1) yields per member per month rates. The maximum number of child dependents that premiums would be collected for is three as determined by Exhibit 3. The premium for the Anthem Dental Family product is the sum of the individual premiums of the Pediatric and Adult benefits multiplied by the Family Factor.

Provider Usage Factor

The Anthem Dental Pediatric/Adult/Family products use the Anthem Prime network. Provider usage factors for the Anthem Dental Pediatric/Adult/Family products are shown in TABLE-7. The factor which applies to participating providers, and the inverse, which applies to non-participating providers, will be applied respectively to determine the Participating Provider premium and the Non-Participating premium in the Rating Worksheet. The final premium rate is then the sum of the premiums for the participating provider benefits and the non-participating provider benefits.

To the best of my knowledge, this rate filing is in compliance with applicable laws and regulations of the state of Colorado, and with the rules of the Department of Insurance. I certify that the rates are not excessive, inadequate or unfairly discriminatory. I also certify that the rates are reasonable in relation to the benefits provided. The actuarial methods, considerations and analysis used in forming my opinion conform to the relevant Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

Robert L Mikkelsen — 7/30/13

Robert L. Mikkelsen, F.S.A., M.A.A.A.
Actuary

Date

Rocky Mountain Hospital and Medical Services, Inc.
Actuarial Memorandum
Anthem Dental Rate Manual

A. Summary

Reason(s) for the rate filing
This is a new rate filing.

Requested Rate Action
No rate action requested as this is a new rate filing and there is no historical data.

Marketing method(s)
This product will be marketed and sold On Exchange by licensed brokers, via the internet and direct response to groups and individuals and their families residing in Colorado. It will be administered by DeCare Dental which is a licensed dental administrator.

Premium classification
Premiums for this product will vary by the following criteria: Benefits covered (coinsurance amounts, annual maximum benefits on adult benefits, deductibles, etc), age of the member which dictates the type of benefits available.

Product descriptions
This dental contract provides a variety of dental benefits that can be provided by an Anthem contracted provider, or a non-contracted provider. A detailed description of the benefit options may be found in the contract filing. In addition, a brief summary of the dental benefits is provided on page 2 of the rate manual portion of this rate filing.

Policy/Rider form
The memorandum address the following policy/rider forms

- Small Group policies: 13-03271.06-SG-EX
- Individual policies: 13-03281.06-IND-EX

Age basis
Members with an issue age below 19 will receive pediatric premiums associated with those benefits. Members with an issue age 19 and older will receive adult premiums associated with those benefits. All renewals will use the renewal age to set premiums.

Renewability provision
This product is guaranteed renewable.

B. Assumption, Acquisition or Merger

The product in this rate filing was not part of an assumption, acquisition, or merger with another company.

C. Rating Period

The rating period for this product and rate filing covers a one year period. The effective date, or the starting date, will be January 1, 2014, and the end date will be one year after the effective date. In addition, the effective date will not be before the approval date of this rate filing by the Colorado Department of Insurance.

D. Underwriting

The insured's application denotes the selected product, and effective date of coverage. An insured that cancels the Anthem dental plan cannot re-enroll for two years.

E. Effect of Law Changes

Not Applicable

F. Rate History

This is a new product and a new rate filing, therefore there is no prior rate history.

G. Coordination of Benefits

All coordination of benefit savings has been reflected in the baseline starting claims cost.

H. Relation of Benefits to Premium

The premiums are determined by developing the claims costs based on benefit design and group or individual's demographics and then dividing that number by the 1 minus the retention. TABLE-9 (given below) details each specific component of the retention load. These expenses are based on anticipated needs of Colorado-specific business. The anticipated retention is 29.46% and therefore the loss ratio is 70.54% which is well above the minimum of 60% set forth in CO regulation 4-24-11, section 6.H.3.b.

Retention Components	**On-Exchange**	**Explanation**
Administration Expense	12.00%	*See Exhibit 7
Premium Tax	1.00%	CO Statute
ACA Insurer Fee	2.46%	Federal Fee
Exchange Fee	0.00%	0 cost
Commission	8.00%	See Exhibit 7
Profit / Contingency	6.00%	*See Section J
Retention	**29.46%**	

I. Lifetime Loss Ratio

The products included in this rate filing were not priced using a lifetime loss ratio standard.

J. Provision for Profit and Contingencies

The Provision for Profit and Contingencies is set at 6% - below the 7% maximum outlined in CO regulation 4-24-11, section 6.J. This 6% is factored into retention to allow for accumulation of fund surplus and reserves necessary for Anthem BCBS to have adequate funds on hand to provide for unexpected claim volatility and fluctuations.

K. Complete Explanation as to How the Proposed Rates were Determined

Please refer to the the Dental Rate Manual that is attached to this memorandum

L. Trend

The starting claim costs were developed for an effective mid-point date of July 1st, 2012. The trend formula is (1 + (trend %/100))^ ((mid-point of rating period – July 1, 2012 expressed in integer half months)/24). Starting July 1st, 2012, claim costs are expected to increase at a trend of 5.00% annually in half-month increments. Premium rates will be guaranteed for 12 months, but for purposes of new sales, will change annually using the middle of the rating period to calculate the trend amount. For example, the January 1st, 2014 to December 31st, 2014 uses a rating period midpoint of June 30th, 2014 in calculating the trend amount.

The 5% projected trend assumption is composed of the following 3 components

- Utilization: 1.5% increase in services per exposure because of the expectation that the influx of previously uninsured will utilize more than the average person in year 1
- Unit cost: 2.0% increase in allowed charges from dental providers because the dental CPI is forecasted to increase more than 3% due to economic improvements and pent up demand to increase prices – this will mostly impact the non-participating provider
- Service Mix: 1.5% increase due to influx of the uninsured that will need more intense (Basic) services than the average policyholders.

Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. The membership steadily grew until 2013 and is starting to level off. As a result of the changing membership, the claim trends do not increase as one would expect because the new membership are selecting plans that have benefits that are less rich. As noted above, we do expect that the membership for Anthem Dental Adult / Pediatric will likely have a lot of pent up demand.

Table L.1

Statistics by Incurred Year

Year	Period	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Net Trend
2010	Starts Apr	4,692	9,009	$241,048	$241,048	$0	1,330	n/a
2011	CY	20,830	40,269	$896,589	$896,589	$0	5,268	-16.8%
2012	CY	38,783	74,929	$1,560,407	$1,556,209	$4,198	9,535	-6.5%
2013	YTD June	22,268	42,983	$863,043	$794,465	$68,577	4,949	-3.6%
All	Total	**86,573**	**167,190**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	

Table L.2

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Month

Year	Month	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts
2010	1	0	0	$0	$0	$0	0
2010	2	0	0	$0	$0	$0	0
2010	3	0	0	$0	$0	$0	0
2010	4	64	148	$4,117	$4,117	$0	22
2010	5	242	448	$11,792	$11,792	$0	60
2010	6	298	556	$12,270	$12,270	$0	76
2010	7	399	743	$19,910	$19,910	$0	116
2010	8	474	905	$22,930	$22,930	$0	134
2010	9	592	1,147	$27,856	$27,856	$0	167
2010	10	730	1,437	$37,886	$37,886	$0	202
2010	11	849	1,655	$43,918	$43,918	$0	234
2010	12	1,044	1,970	$60,369	$60,369	$0	319
2011	1	1,314	2,560	$49,817	$49,817	$0	293
2011	2	1,431	2,799	$57,388	$57,388	$0	357
2011	3	1,517	2,965	$75,785	$75,785	$0	440
2011	4	1,566	3,035	$65,564	$65,564	$0	382
2011	5	1,639	3,158	$76,557	$76,557	$0	442
2011	6	1,654	3,202	$78,525	$78,525	$0	468
2011	7	1,729	3,375	$81,911	$81,911	$0	450
2011	8	1,820	3,532	$93,680	$93,680	$0	557
2011	9	1,882	3,622	$63,690	$63,690	$0	386
2011	10	1,972	3,768	$71,239	$71,239	$0	431
2011	11	2,063	3,962	$80,260	$80,260	$0	480
2011	12	2,243	4,291	$102,173	$102,173	$0	582
2012	1	2,699	5,185	$122,698	$122,666	$32	688
2012	2	2,810	5,419	$112,787	$112,751	$36	701
2012	3	2,892	5,608	$116,880	$116,834	$46	731
2012	4	2,961	5,743	$115,993	$115,924	$70	711
2012	5	3,016	5,832	$113,131	$113,040	$91	746
2012	6	3,092	5,978	$123,423	$123,278	$145	777
2012	7	3,275	6,351	$127,931	$127,724	$207	769
2012	8	3,386	6,557	$148,147	$147,819	$328	908
2012	9	3,437	6,637	$129,136	$128,724	$412	823
2012	10	3,614	6,952	$146,397	$145,760	$637	915
2012	11	3,717	7,154	$152,312	$151,388	$924	899
2012	12	3,884	7,513	$151,572	$150,302	$1,270	867
2013	1	3,869	7,461	$171,506	$169,501	$2,005	979
2013	2	3,849	7,392	$143,835	$141,496	$2,338	828
2013	3	3,785	7,266	$142,227	$138,727	$3,499	897
2013	4	3,786	7,294	$145,004	$138,480	$6,523	871
2013	5	3,583	6,982	$133,282	$122,013	$11,269	782
2013	6	3,396	6,588	$127,189	$84,248	$42,941	592

M. Credibility

This product is new and thus does not have any experience. So, we used a similar product's information displayed in section N. This data is fully credible since there are more than 2,000 life years (24,000 members months) and 2,000 claims –totals are in Table N.1 in Section N.

N. Data Requirements

This is a new product and thus there are no earned premiums, incurred claims, actual benefits ratios, number of claims, average covered lives and number of policyholders to submit on a Colorado-only basis for at least 3 years. Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. Below is the yearly summary.

Table N.1

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Year

													Average	
Year	Period	Subscriber Months	Member Months	Billed Premium	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Loss Ratio	Premium PMPM	Incurred PMPM	Net Trend	Subscribers	Members
2010	Starts Apr	4,692	9,009	$294,677	$241,048	$241,048	$0	1,330	82%	$32.71	$26.76	n/a	616	1,183
2011	CY	20,830	40,269	$1,288,819	$896,589	$896,589	$0	5,268	70%	$32.01	$22.26	-16.8%	1,872	3,608
2012	CY	38,783	74,929	$2,428,330	$1,560,407	$1,556,209	$4,198	9,535	64%	$32.41	$20.83	-6.5%	3,424	6,614
2013	YTD June	22,268	42,983	$1,389,503	$863,043	$794,465	$68,577	4,949	62%	$32.33	$20.08	-3.6%	3,636	7,031
All	Total	**86,573**	**167,190**	**$5,401,329**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	**66%**	**$32.31**	**$21.30**			

O. Side-by-Side Comparison

This is a new product and thus there is nothing that can be compared.

P. Benefits Ratio Projections

The following is the 2014 projection of incurred claims, revenue and benefit loss ratios. Note that this is a new filing and there is no rate change request –that's why there are zeroes in the "Without Change" section.

Table P.1

	With Change			Without Change		
Date	**Prem**	**Clms**	**LR**	**Prem**	**Clms**	**LR**
1/1/2014	$459,985	$335,581	73%	$0	$0	n/a
2/1/2014	$633,483	$396,456	63%	$0	$0	n/a
3/1/2014	$797,830	$526,635	66%	$0	$0	n/a
4/1/2014	$825,590	$557,156	67%	$0	$0	n/a
5/1/2014	$822,762	$525,419	64%	$0	$0	n/a
6/1/2014	$820,104	$540,782	66%	$0	$0	n/a
7/1/2014	$821,525	$543,676	66%	$0	$0	n/a
8/1/2014	$819,824	$524,673	64%	$0	$0	n/a
9/1/2014	$819,182	$495,312	60%	$0	$0	n/a
10/1/2014	$820,334	$526,982	64%	$0	$0	n/a
11/1/2014	$818,546	$460,460	56%	$0	$0	n/a
12/1/2014	$843,376	$622,756	74%	$0	$0	n/a

Q. Other Factors

Please refer to the information below and the Dental Rate Manual that is attached to this memorandum.

Proposed Premium Rates PMPM

The rates to use (in Table Q.1) multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. The propose premium rates are on per member per month (PMPM) basis.

Table Q.1

		Premium PMPM			
		70 % AV		85% AV	
CO Product IDs	Description of Product	Adult	Pediatric	Adult	Pediatric
87269CO107	SG PPO Pediatric Dental On Exchange		$17.90		$20.92
87269CO108	SG PPO Adult Dental On Exchange	$24.93		$33.17	
87269CO109	SG PPO Family Dental On Exchange	$24.31	$17.46	$37.52	$25.58
87269CO110	Individual PPO Pediatric Dental On Exchange		$17.90		$20.92
87269CO111	Individual PPO Adult Dental On Exchange	$24.93		$33.17	
87269CO112	Individual PPO Family Dental On Exchange	$24.31	$17.46	$37.52	$25.58

Anthem Blue Cross Blue Shield Policy Form No 13-03271.06 & 13-03281.06

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Family Low Plan On-Exchange	87269CO1120001	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000	1.0000	1.0000	1.0000	0.4850	0.4820	0.4775
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17	$19.29	$11.79	$8.25	$9.36	$5.68	$3.94
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00			$39.33			$18.98	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9400			0.9400	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.66			$5.30			$13.67			$6.41	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.44			$7.51			$19.37			$9.09	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$9.44	$19.37
Non-Participating Program	$7.51	$9.09
Total	**$16.95**	**$28.46**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric	Adult
Total		**$0.51**	**$0.00**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$17.46**	**$28.46**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$131.30**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Pediatric Low Plan On-Exchang	87269CO1100001	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.83			$5.44	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.69			$7.70	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$9.69
Non-Participating Program	$7.70
Total	**$17.39**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric
Total		**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$17.90**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Family High Plan On-Exchange	87269CO1120002	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6499	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric	Adult
Total		**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: Individual Pediatric High Plan On-Exchang	87269CO1100002	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$8.17			$6.23	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.58			$8.83	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$11.58
Non-Participating Program	$8.83
Total	**$20.41**

Ortho Premium	Refer to Exhibit 5 and	Pediatric
Total	Step 17	**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$20.92**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Family Low Plan On-Exchange-	87269CO1090001	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000	1.0000	1.0000	1.0000	0.4850	0.4820	0.4775
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17	$19.29	$11.79	$8.25	$9.36	$5.68	$3.94
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00			$39.33			$18.98	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9400			0.9400	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.66			$5.30			$13.67			$6.41	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.44			$7.51			$19.37			$9.09	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$9.44	$19.37
Non-Participating Program	$7.51	$9.09
Total	**$16.95**	**$28.46**

Ortho Premium (Refer to Exhibit 5 and Step 17)	Pediatric	Adult
Total	**$0.51**	**$0.00**

Final Premium Rate (Refer to Step 18)	Pediatric	Adult
Total	**$17.46**	**$28.46**

Final Total Premium Rate (Refer to Step 19)	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total	**1**	**4**	**$131.30**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Pediatric Low Plan On-Exchange-	87269CO1070001	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.0000	1.0000	1.0000	0.7622	1.0000	1.0000
Adjusted starting claim cost		Product of above 2 lines	$13.10	$3.85	$0.17	$9.98	$3.85	$0.17
Combined Claim Cost		Sum of the 3 Classes		$17.12			$14.00	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$6.83			$5.44	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$9.69			$7.70	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$9.69
Non-Participating Program	$7.70
Total	**$17.39**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric
Total		**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$17.90**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Family High Plan On-Exchange-	87269CO1090002	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6499	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium (Refer to Exhibit 5 and Step 17)	Pediatric	Adult
Total	**$5.68**	**$5.17**

Final Premium Rate (Refer to Step 18)	Pediatric	Adult
Total	**$25.58**	**$37.52**

Final Total Premium Rate (Refer to Step 19)	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total	**1**	**4**	**$175.66**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name: SG Pediatric High Plan On-Exchange-	87269CO1070002	Product	Anthem Dental Family Enhanced
Location (Zip Code)	81612	Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan					
			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000	
Geographic area adjustment	1.020	Refer to TABLE-4		1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000	
Provider Usage factor		Refer to TABLE-7		0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000	
Family Factor	1.0000	Refer to TABLE-8		1.0000			1.0000	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$8.17			$6.23	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.58			$8.83	

Blended Premium Rate (Two Tier Rates)	Pediatric
Participating Program	$11.58
Non-Participating Program	$8.83
Total	**$20.41**

Ortho Premium	Refer to Exhibit 5 and Step 17	Pediatric
Total		**$0.51**

Final Premium Rate	Refer to Step 18	Pediatric
Total		**$20.92**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums
Total		**1**

The purpose of this filing is to demonstrate compliance with minimum requirements of the state of Colorado and show that the benefits are reasonable in relation to premiums charged.

This Anthem Blue Cross and Blue Shield (Anthem BCBS) Anthem Dental Rate Manual applies to the Anthem Dental Pediatric/Adult/Family products which are HCR compliant. This rate manual applies to rates that are being used and developed on behalf of Rocky Mountain Hospital and Medical Services, Inc, also doing business as Anthem BCBS. This rate manual applies to Small Group policies 13-03271.06-SG-EX &, Individual policies 13-03281.06-IND-EX,. Individuals will be able to select plans with a range of benefit design options. This rate manual and the rates developed by it will be effective January 1st, 2014.

The rating method begins with starting claim costs. Factors are then applied to these costs that develop rates based on the member's benefit plan. The methodology will use linear interpolation to derive the appropriate factors for benefits not explicitly stated in this rate manual. The rating steps are shown in the two rating worksheets in the back of the Anthem BCBS Anthem Dental Rate Manual. Exhibit 1 shows the rating worksheet template, and Exhibit 2 shows a sample rate calculation.

Definitions

Class of Dental Services
Class I – Diagnostic and Preventive
Class II – Basic services; simple restorations, periodontics, endodontics and oral surgery
Class III – Major restorative services; prosthodontics and prosthetics
Class IV – Orthodontics; Dentally Necessary Orthodontics

Pediatric – Pediatric EHB Mandated Dental Benefits for individuals up to the age of 19
Adult – Dental Benefits for individuals age 19 and over
Family – Pediatric and Adult benefits purchased as a single contract. Individuals up to the age of 19 receive Pediatric benefits and individuals age 19 and over receive Adult benefits.
AV – Actuarial Value measured using benefits when using a participating provider represents the percentage of costs covered by the plan

Plan Offerings

Anthem Dental Pediatric Plan – Pediatric dental benefit with 70% AV
Anthem Dental Pediatric Enhanced Plan – Pediatric dental benefit with 85% AV
Anthem Dental Adult Plan – Adult dental benefit
Anthem Dental Adult Enhanced Plan – Adult dental benefit with higher coinsurance levels
Anthem Dental Family Plan – A combination of Anthem Dental Pediatric Plan and Anthem Dental Adult Plan with benefits based on the age of family members
Anthem Dental Family Enhanced Plan – A combination of Anthem Dental Pediatric Enhanced Plan and Anthem Dental Adult Enhanced Plan with benefits based on the age of family members; includes cosmetic orthodontia for children from age 8 up to age 19

Morbidity

The starting claim cost for each class of service (Diagnostic & Preventive, Basic, Major, and Orthodontics) is based on analyses of several recent years of claim data. An extensive claim database was used to derive this experience. This data is supplemented as needed by data provided by Milliman USA, an Actuarial Consulting firm.

Analyses were conducted separately for each of the following services: diagnostic and preventive, basic restorative, periodontic, endodontic, oral surgery, major restorative, prosthodontics, prosthetic repairs and orthodontics. The results were then aggregated into Class I, Class II, Class III and Class IV services.

The starting claim costs are developed assuming reimbursement at the full amount of the dentist submitted charge, where the dentist submitted charge is equal to a national average. The starting claim costs experience has a midpoint date of July 1, 2012.

The monthly starting Pediatric and Adult benefit claim costs are:

	Pediatric	Adult
Class I Diagnostic and Preventive Services	$13.10	$19.29
Class II Basic Services	$ 3.85	$11.79
Class III Major Services	$ 0.17	$ 8.25
Class IV Orthodontic Services	$ 0.39	$ 0.00

The Adult plans starting claim costs assume coinsurance levels of 100% for Class I services, 50% for Class II services, 50% for Class III services, a $50 per person deductible and a $1,200 annual maximum. The specific procedures defined by the PPACA Stand-Alone Dental Plan Procedures for Colorado dated May 31, 2013 are the only procedures covered in the Pediatric starting claim costs. The Pediatric starting claim costs assume coinsurance levels of 90% for Class I services, 50% for Class II services, 50% for Class III services, and also include Class IV Orthodontic Services as Dentally Necessary Orthodontia assuming a coinsurance level of 50%. All Pediatric plan starting claim costs assume no annual maximum and an out-of-pocket maximum of $700 per member up to a maximum of $1,400 per family. The pediatric plans also include a $50 deductible for non-Diagnostic & Preventive services which is included in the starting claim costs. TABLE-1 (see Rate Manual for Tables TABLE-1 through TABLE-10 referenced in this Actuarial Memorandum) lists the coinsurance percentages being offered and their corresponding adjustment factors for each of the three classes of services to reflect the differences from the coinsurance levels used to establish the starting claim costs. Due to the out-of-pocket maximum on the pediatric benefit, Class IV claim costs will not change with varying coinsurance.

Pediatric EHB Actuarial Value

The model used to develop the Actuarial Value (AV) for the pediatric EHB plans was comprised of dental claims data of members under the age of 19. The data was used to develop annual utilization by procedure code for all covered services under the pediatric EHB while including utilization adjustments for non-traditional benefits such as no annual max and an annual out-of-pocket maximum. Average allowed amounts by procedure were used to establish a total claim costs by benefit category for In-Network claims. Coinsurance levels where then determined by benefit category, defined as Class I through Class V in the preceding paragraph, and the ratio of the resulting claim costs with coinsurance to the total claim costs with 100% coverage is then verified to be within the AV of 70% plus or minus 2% or 85% plus or minus 2%.

Actuarial Value Calculation

The Actuarial Value (AV) calculation is determined as the ratio of the EHB claim costs of a certain benefit set in comparison to the claim costs of 100% coverage of the same benefits for In Network providers. The starting claim costs are adjusted for necessary coinsurance adjustments by pediatric benefit class using Table 1A. The table below shows the AV calculation for the Anthem Dental Pediatric Plans.

Benefit Class	Starting Claim Cost	Anthem Dental Pediatric	Anthem Dental Pediatric Enhanced	100% Coverage w/no deductible
Class I	$13.10	$13.10	$14.85	$15.31
Class II	$3.85	$3.85	$5.45	$8.34
Class III	$0.17	$0.17	$0.17	$0.39
Class IV	$0.36	$0.36	$0.36	$0.54
Total Claim Cost	$17.48	$17.48	$20.83	$24.57
Actuarial Value		**71.2%**	**84.8%**	

Mortality

Not Applicable

Persistency

Not Applicable

Premium Modalization Rules

Not Applicable

Claim Liability and Reserves

Incurred but not paid (IBNP) reserves which includes an amount for claim amounts reported but not yet paid will be established using a lag factor approach. This method uses claim payment histories to estimate the amount of claims that have been incurred in a particular time period. From the incurred amount, the actual paid amount is subtracted to get the IBNP reserve.

Active Life Reserves

Not Applicable, there are no active life reserves for this product.

Coinsurance Adjustment

Coinsurance amounts may be equal for benefits provided by participating providers, or they may differ depending on whether the member gets services from a participating or a non-participating provider. Additionally, coinsurance amounts may differ between Pediatric and Adult plans. To determine the coinsurance adjustment factors that apply to a given product option, refer to TABLE-1.

Deductible Adjustment

Deductibles, if present, are $50 per person per benefit year. Deductible factors are applied to Adult plan claim costs. The benefit year deductible can either apply to diagnostic and preventive services, or it can be waived for diagnostic and preventive services. Factors for the two deductible options are found in TABLE-2. Pediatric plans are subject to a $50 deductible on non-Class I services.

Annual Maximum Adjustment

The annual maximum for each person can be between $500 and $2,000 per benefit year. Adjustment factors are shown in TABLE-3. Pediatric benefits do not have an annual maximum amount on participating provider benefits and a $1,000 annual max on non-participating provider benefits which is reflective in the Pediatric starting claim costs.

Dependent Age Adjustment

Dependents are children of the individual. All product options assume that children of enrolled individuals are covered up to age 26, regardless if they are a student or not.

If the dependent child is under the age of 19, they will have a Pediatric EHB dental benefit plan design. If the dependent child is between the ages of 19 up to age 26, they will receive an Adult dental benefit plan design. Dependent coverage up to age 26 is assumed in the starting claims cost, so no claim factors are needed for this pricing assumption.

Geographic Area Adjustment

Anthem BCBS only markets to individuals who reside in the state of Colorado. This rating model does not use different geographic areas within Colorado, therefore the rates developed in this model are used for the entire state of Colorado. Given that rates apply to the entire state, one geographic area adjustment factor is used for all rates.

The Geographic Area Adjustment varies by rating area and is in TABLE-4.

Occupational Adjustment

An occupational adjustment factor is not used in this rating model.

Prior Coverage

These Anthem Dental products may have waiting periods for Class II and Class III services for Adult plans, as discussed below. In some circumstances, if the individual purchaser has had prior comparable coverage, waiting periods will be waived. However, prior coverage is not a pricing variable used in the pricing model. There is no waiting period for Pediatric EHB benefits.

Benefit waiting period factor

Certain Adult plans may have waiting periods before certain categories of services will be covered under the plan. These waiting periods can apply to basic services, major services. If applicable, the waiting period for basic services will be 6 months, and the waiting period for major services will be 12 months. For purposes of waiting periods, Endodontic, Periodontic, and Oral Surgery services are included in major services and have a 12 month waiting period. The Pediatric EHB benefit does not have any waiting periods on services other than dentally necessary orthodontia, which has a 12 month waiting period which is figured into the

orthodontia starting claim cost. The appropriate adjustment for claims cost can be found in TABLE-5.

Reimbursement

The assumed level of provider reimbursement in the starting claims cost is set at the average of national dental submitted charges. The allowed reimbursement for the Anthem Dental Pediatric/Adult/Family products are the same whether or not the member sees a participating provider or a non-participating provider. The reimbursement adjustment factors for the Anthem Dental Pediatric/Adult/Family products are found in TABLE-6.

Orthodontia

Dentally necessary orthodontia is part of the Pediatric EHB benefit. When a non-participating provider is used, there is a $1,000 Lifetime Maximum benefit. There is no Lifetime Maximum benefit when a participating provider is used. Supplemental cosmetic child orthodontia is included for family purchasers that select the Anthem Dental Family Enhanced Plan for child dependents age 8 up to age 19.

Retention

Retention is a percentage of gross premiums and includes administrative expense, profit and Contingency, and premium tax as required. The retention table is shown in TABLE-9. The retention also includes provision for a writing agent commission as well as a commission override if applicable. The retention breakout differs between products sold On-Exchange, however the total retention is equivalent to achieve the same price as shown in TABLE-9.

Expected Loss Ratio

The expected loss ratio for this product is 70.54%. This equals 100% less the retention percentage.

Premium

The Anthem Dental Rating Worksheet (Exhibit 1) yields per member per month rates. The maximum number of child dependents that premiums would be collected for is three as determined by Exhibit 3. The premium for the Anthem Dental Family product is the sum of the individual premiums of the Pediatric and Adult benefits multiplied by the Family Factor.

Provider Usage Factor

The Anthem Dental Pediatric/Adult/Family products use the Anthem Prime network. Provider usage factors for the Anthem Dental Pediatric/Adult/Family products are shown in TABLE-7. The factor which applies to participating providers, and the inverse, which applies to non-participating providers, will be applied respectively to determine the Participating Provider premium and the Non-Participating premium in the Rating Worksheet. The final premium rate is then the sum of the premiums for the participating provider benefits and the non-participating provider benefits.

To the best of my knowledge, this rate filing is in compliance with applicable laws and regulations of the state of Colorado, and with the rules of the Department of Insurance. I certify that the rates are not excessive, inadequate or unfairly discriminatory. I also certify that the rates are reasonable in relation to the benefits provided. The actuarial methods, considerations and analysis used in forming my opinion conform to the relevant Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

Robert L Mikkelsen 7/30/13

Robert L. Mikkelsen, F.S.A., M.A.A.A.
Actuary

Date

June 14, 2013

Colorado Department of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Re: Anthem Dental Pediatric Adult Family Enhanced
Type of Filing: Rates
Effective Date: October 1, 2013

Dear Reviewer,

Enclosed are new rates for our Anthem Dental Pediatric Adult Family Enhanced product. This product is intended for sale on and off Exchange in the small group market. The forms for this product will be submitted in the last week of June and will be under SERFF tracking number ANTV-129075343.

On Exchange, we intend to offer pediatric only plans that contain Essential Health Benefits. We also intend to offer family plans that contain the Essential Health Benefits, as well as benefits for adults. Off Exchange, we will offer both pediatric and family plans, and in addition will offer an adult only plan.

Please note, a binder submission for these products will be submitted on a separate filing.

Also included in this filing is the HR-1 form and an Actuarial Memorandum under the Supporting Documentation tab.

Sincerely,

Brenda Davis
Contract Administrator

SERFF Tracking #:	*ANTV-129075587*	***State Tracking #:***	*278985*	***Company Tracking #:***	

State:	*Colorado*	***Filing Company:***	*Rocky Mountain Hospital and Medical Service, Inc. D.B.A. Anthem Blue Cross and Blue Shield*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*Anthem Dental Pediatric Adult Family Enhanced SG Rates*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/19/2013		Rate	Dental Rate Manual for On Exchange	07/31/2013	Dental Rate Manual for On Exchange.pdf (Superceded)
07/19/2013		Rate	Dental Rate Manual for Off Exchange	07/31/2013	Dental Rate Manual for Off Exchange.pdf (Superceded)
07/19/2013		Supporting Document	Actuarial Memorandum	07/31/2013	Actuarial Memorandum for Off Exchange.pdf (Superceded) Actuarial Memorandum for On Exchange.pdf (Superceded)
07/12/2013		Supporting Document	Actuarial Memorandum	07/19/2013	Actuarial Memorandum v3.pdf (Superceded)
07/12/2013		Rate	Dental Rate Manual	07/19/2013	Dental Rate Manual v3.pdf (Superceded)
06/27/2013		Rate	Dental Rate Manual	07/12/2013	Dental Rate Manual v2.pdf (Superceded)
06/27/2013		Supporting Document	Actuarial Memorandum	07/12/2013	Actuarial Memorandum v2.pdf (Superceded)
06/14/2013		Rate	Dental Rate Manual	06/27/2013	Dental Rate Manual.pdf (Superceded)
06/14/2013		Supporting Document	HR-1 Form (H)	06/27/2013	HR-1 SG.pdf (Superceded)
06/14/2013		Supporting Document	Actuarial Memorandum	06/27/2013	Actuarial Memorandum.pdf (Superceded)

Anthem Blue Cross Blue Shield

ANTHEM DENTAL RATE MANUAL

Anthem Dental Pediatric/Adult/Family Products

Table of Contents

Schedule of Benefits
The following schedules of benefits will be made available to individuals depending on the member's age. Note that the schedule of benefits, for the non-participating provider benefit schedule could be different than the participating provider benefit schedule. Also, the schedule of benefits could be different for Adult members and Pediatric members.

Anthem Dental Pediatric/Adult/Family

Adult Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative*	NC or 10% to 90%
Endodontics*	NC or 10% to 90%
Periodontics*	NC or 10% to 90%
Oral Surgery*	NC or 10% to 90%
Major Restorative*	NC or 10% to 60%
Prosthetic Repairs/Adjustments*	NC or 10% to 60%
Prosthetics*	NC or 10% to 60%
Orthodontics*	NC

* NC denotes no coverage

Individual Deductible	$50 per person
Family Deductible	$50 per person
Annual Maximum	$500 - $2,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Deductible levels available at $50 at the individual level.
Annual maximum available within the range in increments of $250.
Annual Out-Of-Pocket (OOP) Maximum is not available.

Pediatric Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative	50% to 90%
Endodontics	50% to 90%
Periodontics	50% to 90%
Oral Surgery	50% to 90%
Major Restorative	50% to 60%
Prosthetic Repairs/Adjustments	50% to 60%
Prosthetics	50% to 60%
Dentally Necessary Orthodontics	50% to 60%
Cosmetic Orthodontics*	NC or 50% to 60%

* NC denotes no coverage

Individual Deductible	$50
Family Deductible	$50 per person
Annual Maximum	N/A for Participating Providers; $1,000 for Non-Participating Providers
Annual Out of Pocket Maximum Individual/Family	$700/$1,400
Dentally Necessary Orthodontics Maximum	No Maximum for Participating Providers; $1,000 LT Max for Non-Participating Providers
Cosmetic Orthodontia Lifetime Maximum	$1,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Annual Out-Of-Pocket (OOP) Maximum on Pediatric EHB plans of $700 per member up to a maximum of $1,400 per family.

Plan Options Available

- Cosmetic Orthodontia is included with the Anthem Dental Family Enhanced Plan for children age 8 up to age 19
- Annual OOP Maximum may be $1,000 per member up to a maximum of $2,000 per family

Individual Dental Rate Manual Instructions

All calculations can be completed in the following Anthem Dental Rating Worksheet (see Exhibit 1). Linear interpolation is to be followed to derive the appropriate factors for benefits not explicitly given in this rate manual.

Step 1: Fill in the benefit plan information: the Individual's name, the product selected, location, and the effective date of the contract. Note that the benefits may vary between the participating provider columns and the non-participating columns as well as between Adult and Pediatric columns. Note that 100/80/50 denotes coverage at 100% for Diagnostic and Preventive (Class I), 80% coverage for Basic Restorative (Class II), and 50% coverage for Major Restorative (Class III).

Step 2: Coinsurance Adjustment Coinsurance adjustment factors (see TABLE-1) are given for different combinations of services. Based on the plan's benefits, find the appropriate set of coinsurance adjustment factors in TABLE-1A & TABLE-1B for Pediatric and Adult benefits respectively, and enter them in the appropriate coinsurance adjustment worksheet (Exhibits 4A & 4B) and enter the results of coinsurance adjustment worksheet into the coinsurance adjustment row of the rating worksheet.

Step 3: Multiply the Adult and Pediatric starting claim cost by the appropriate coinsurance adjustment factor for each class of service. Enter the results on the line in Exhibit 1 labeled "Adjusted starting claim cost". On the line labeled "Combined claim cost" enter the sum of the Class I, Class II, and Class III adjusted starting claim costs.

Step 4: Enter the Deductible adjustment from TABLE-2. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to a deductible and that is reflected in the Pediatric starting claim costs.

Step 5: Based on the plans annual maximum benefit, enter the appropriate annual maximum adjustment factor from TABLE-3. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to an annual max and that is reflected in the Pediatric starting claim costs.

Step 6: Geographic Area Adjustment: Refer to TABLE-4, and pick the appropriate factor based on the three-digit zip code the member resides in. Enter the factor on the rating sheet.

Step 7: Annual Trend The starting claim costs were developed with a baseline date of July 1, 2012. Claim costs are expected to increase at a trend of 5.00% annually in half month increments. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$. Enter the compounded trend amount on the annual trend line on the rating worksheet. For example if the quote applies to period of January 1st, 2014 to December 31st, 2014, the trend period is from July 1st, 2012 to June 30th, 2014 (the mid-point of the rating period), or 48 half months.

Step 8: For benefit plan designs that include waiting periods for certain benefit categories, the appropriate factor in TABLE-5 will be entered in the columns on the line labeled "Benefit Waiting Period factor". For Pediatric plans, the factor is 1.00 because the Pediatric benefits are not subject to waiting periods and that is reflected in the Pediatric starting claim costs.

Step 9: Reimbursement Factor: Refer to TABLE-6, and pick the appropriate factor based on the member's three-digit zip code and enter it on the rating sheet. The same factor will be used in the in the participating provider columns and the non-participating provider columns for both Pediatric and Adult plans.

Step 10: Provider Usage Factor: Refer to TABLE-7, and enter the provider usage factors in the appropriate columns.

Step 11: Out-of-Pocket Maximum Factor: The Pediatric dental benefit has an annual Out-of-Pocket Maximum of $700 for an individual up to a limit of $1,400 for the family priced into the Pediatric dental product and has a factor of 1.00 in the rating worksheet. If a $1,000 Out-of-Pocket Maximum for an individual up to a limit of $2,000 for the family members up to the age of 19 is used, a factor of .975 is used for the Out-of-Pocket Maximum factor line in the Pediatric columns in the rating worksheet.

Step 12: Family Factor: Enter the appropriate Family Factor from TABLE-8 depending on the product that is purchased. For purchasers of an Anthem Dental Family product, the Family Factor is to account for administrative efficiencies and decreased anti-selection risk of a family purchasing instead of individual purchasers of separate Pediatric and Adult policies.

Step 13: On the line labeled "Total Claim Cost", enter the product of multiplying the combined claim cost from step 3 by the factors in steps 4 through 12.

Step 14: Retention: Enter 1 minus the retention amount from TABLE-9. The expected loss ratio for this product is 70.54% for On-Exchange.

Step 15: On the line labeled "Gross Monthly Premium": enter the result of dividing the amount from step 13 by the amount in step 14.

Step 16: Blended Premium: To determine the blended premium rate, add the results from step 14, for the Participating Provider column, and the Non-Participating Provider column. Do this for both the Pediatric and Adult columns.

Step 17: Ortho Premium: The orthodontia premium is calculated in Exhibit 5. Dentally Necessary Orthodontia is included in all Pediatric plans and is the Pediatric class IV claim cost. This amount should be entered into the line 1 of Exhibit 5 under the Pediatric column. For the Anthem Dental Family Enhanced product, cosmetic orthodontia is included for members age 8 up to age 19 and the claim cost of the cosmetic orthodontia is located in TABLE-10 and entered in line 2 of Exhibit 5 in both the Pediatric and Adult columns. The sum of the costs for the Pediatric and Adult costs are entered in line 3 of Exhibit 5. In line 4 of Exhibit 4, enter 1 minus the retention percentage from TABLE-9. In Exhibit 5, line 5 equals

line 3 divided by line 4 to give the orthodontia premium amount to enter for the Orthodontia Premium in the rating worksheet.

Step 18: Final Premium Rates: Enter the sum of the Blended Premium Rate and Ortho Premium from step 16 and step 17 and enter into the Final Premium Rate for both the Pediatric and Adult columns.

Step 19: For the Anthem Dental Pediatric and Anthem Dental Adult products, the rates from step 18 are the rates to use multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. For the Anthem Dental Family products, Exhibit 3 is used to calculate the number of pediatric and adult premiums that will be rated for based on the makeup of the family, and the resulting values from Exhibit 3 are used in the Rating Worksheet for the Number of Pediatric Premiums and the Number of Adult Premiums, respectively. The Total Contract Premium is calculated by multiplying the rates in the Pediatric column from step 18 by the Number of Pediatric Premiums and adding the product of the Final Premium Rate in the Adult column from step 18 and the Number of Adult Premiums.

TABLE - 1A
Pediatric Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.1111	1.020	100%	2.000	1.050	100%	2.000	1.100
90%	1.0000	1.000	80%	1.600	1.041	50%	1.000	1.000
80%	0.8889	0.990	60%	1.200	1.010			
70%	0.7778	0.980	50%	1.000	1.000			

Default plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4A for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 1B
Adult Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.0000	1.000	90%	1.800	1.046	60%	1.200	1.030
90%	0.9000	0.993	80%	1.600	1.026	50%	1.000	1.000
80%	0.8000	0.992	60%	1.200	1.005	30%	0.600	0.965
75%	0.7500	0.988	50%	1.000	1.000	25%	0.500	0.955
50%	0.5000	0.970	30%	0.600	0.974	15%	0.300	0.945
			25%	0.500	0.964	0%	0.000	0.000
			15%	0.300	0.944			
			0%	0.000	0.000			

Default plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4B for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 2

Benefit Year Deductible Factors

	Factor
Deductible does not apply to Diagnostic and Preventive Services	1.00
Deductible does apply to Diagnostic and Preventive Services	0.95

Note:
A $50 per person deductible will apply to any Adult benefit set. The only variable regarding the deductible is whether or not the deductible applies to Diagnostic and Preventive Services. A $50 deductible applies to non-D&P services for Pediatric plans.

TABLE - 3

Annual Maximum Benefit Factors

Annual Maximum Amount	Factor
$500	0.9100
$750	0.9400
$1,000	0.9690
$1,200	1.0000
$1,250	1.0078
$1,500	1.0600
$1,750	1.0950
$2,000	1.1300
$2,500	1.2200

Note: For a quote that has D & P coverage only, annual maximum factors for all amounts equals amounts equals 1.00. Pediatric plans do not have an annual max therefore have a factor of 1.00 because the unlimted maximum is built into the starting claim cost.

TABLE - 4

Geographic Area Adjustment

Rating Area	Factor
Statewide	1.020

TABLE - 5

Benefit Waiting Period Factors

Services Covered	Factor
6 month waiting period on Basic Restorative and 12 month on non-D&P	0.975
12 month waiting period on Class III Only	1.000
Class I, Class II, and Class III are all covered with no waiting period	1.050

Note: Pediatric plans do not have waiting periods on non-orthodontia services therefore get a factor of 1.00.

TABLE - 6

Reimbursement Factors

Rating Area - Three-Digit Zips Included	Factor
Statewide	
Prime Network Reimbursement Factor	0.700
Non-Participating Reimbursement Factor	0.700

TABLE-7

Provider Usage Factors

Rating Area - Three-Digit Zips Included	**Factor**
Statewide	
Prime Network Usage Factor	0.507
Non-Participating Usage Factor	0.493

TABLE - 8

Family Factor

Product	**Factor**
Anthem Dental Pediatric Products	1.0000
Anthem Dental Adult Products	1.0000
Anthem Dental Family Products	0.9750

TABLE - 9

Retention Factor

	Retention as % of Premium	
	On-Exchange	Off-Exchange
Administration Expense	12.00%	12.00%
Premium Tax	1.00%	1.00%
ACA Insurer Fee	2.46%	2.46%
Exchange Fee	0.00%	0.00%
Commission	8.00%	8.00%
Profit / Risk Charge	6.00%	6.00%
Retention	**29.46%**	**29.46%**

TABLE - 10

Orthodontia Claim Costs

Orthodontia Benefit	**Claim Cost**
Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.36
Cosmetic Orthodontia per member per month cost $1,000 Lifetime Maximum with 12 Month Waiting Period Costemic Orthodontia is all orthodontia cases not deemed Dentally Necessary Orthodontia	$3.65
Dentally Necessary with no cost share for AV calculation Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.54

Exhibit 1 -- Individual Dental Rating Worksheet

Name	Product
Location (Zip Code)	Effective Date

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1												
Adjusted starting claim cost		Product of above 2 lines												
Combined Claim Cost		Sum of the 3 Classes												
Deductible adjustment		Refer to TABLE-2												
Annual maximum adjustment		Refer to TABLE-3												
Geographic area adjustment		Refer to TABLE-4												
Annual trend		Refer to Step 7												
Benefit waiting period factor		Refer to TABLE-5												
Reimbursement factor		Refer to TABLE-6												
Provider Usage factor		Refer to TABLE-10												
Out-Of-Pocket Max Factor		Refer to Step 11												
Family Factor		Refer to TABLE-8												
Total Claim Cost		Product of Combined Claims Cost factors and adjustments												
Retention	29.46%	Refer to TABLE-9	70.54%			70.54%			70.54%			70.54%		
Gross Monthly Premium		Total claim cost divided by (1 - Retention)	$0.00			$0.00			$0.00			$0.00		

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program		
Non-Participating Program		
Total	**$0.00**	**$0.00**

Ortho Premium	Refer to Exhibit 4 and Step 17	Pediatric	Adult
Total			

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total			

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total				**$0.00**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name	J. Doe
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6500	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.0200	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-10		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 4 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 3 -- Anthem Dental Family Product -- Number of Rates Worksheet

Name	J. Doe
Product	Anthem Dental Family Enhanced

Number of members in family	6
Number of non-child members (a)	2
Number of child members age 19 and older (b)	2
Number of child members under age 19 (c)	2

Number of non-child members to be rated (d):	2
Take the number (a)	
Number of children age 19 and older to be rated (e):	2
Take the lesser of (b) and 3	
Number of children age under age 19 to be rated (f)	1
Take the lesser of 3 minus (d) or (c)	

Number number of adult premiums rated	**4**
Take the sum of (d) and (e)	
Number of pediatric premiums to be rated for (f)	**1**

Exhibit 4A -- Pediatric Dental Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	90	50	50	50
3 Claim Impact Factors (Table-1)	1.111	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0200	1.0410	1.0000	1.0000
5 Total Change	1.1333	1.6656	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.6260	0.3740	1.0000
7 Total Weighted Change	1.1333	1.0427	0.3740	1.0000
8 Coinsurance Factor for Exhibit1	1.1333	1.4167		1.0000

Baseline plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 4B -- Adult Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	100	50	50	50
3 Claim Impact Factors (Table-1)	1.000	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0000	1.0260	1.0000	1.0000
5 Total Change	1.0000	1.6416	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.5283	0.4717	1.0000
7 Total Weighted Change	1.0000	0.8673	0.4717	1.0000
8 Coinsurance Factor for Exhibit1	1.0000	1.3390		1.0000

Baseline plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 5 -- Orthodontia Premium Worksheet		
Product		
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)		
Cosmetic Orthodontia (line 2)		
Total Orthodontia Claim Cost (line 3)		
Retention (line 4)		
Orthodontia Premium (line 5)		

Exhibit 6 -- Orthodontia Premium Worksheet -- Sample Calculation		
Product	Anthem Dental Family Enhanced	
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)	$0.39	$0.00
Cosmetic Orthodontia (line 2)	$3.65	$3.65
Total Orthodontia Claim Cost (line 3)	4.04	3.65
Retention (line 4)	70.54%	70.54%
Orthodontia Premium (line 5)	5.73	5.17

Exhibit 7

Development and Justification for Administrative Expense Load and Commission Load

Colorado Prime Network Products

These Prime Network dental products are administered by DeCare Dental which is a wholly owned subsidiary of WellPoint Inc. Anthem Blue Cross Blue Shield of Colorado is also a subsidiary of WellPoint Inc.

ADMINISTRATIVE EXPENSE

(a)	DeCare Dental administers a large block of small group dental risk products. Total incurred costs for administrative expenses for 2010 for the small group dental risk business administered by DeCare dental was:	$19,279,150
(b)	Total earned premium for 2010 for the small group dental risk business administered by DeCare Dental and mentioned in (a) above was:	$126,399,305
(c)	Incurred administrative costs as a percent of earned premium for 2010 for DeCare Dental's small group dental risk business was (a)/(b) which equals:	15.25%
(d)	Average annual premium per member per month (PMPM) for the small group dental business administered by DeCare Dental:	$24.43
(e)	Average monthly premium per member per month (PMPM) for the HCR compliant Prime Network business expected in Colorado:	$30.87
(f)	Ratio of average premium PMPM for DeCare small group business to expected average PMPM premium for Colorado Prime Network HCR business, equals (d) / (e):	0.791
(g)	Since the average expected Colorado dental premium is greater than the average DeCare small group dental premium, a lower percent of premium is needed to generate the needed administrative expense to operate the CO small group Prime % Complete business. That percentage is equal to (f) x (c) which equals:	12.07%

Anthem Blue Cross Blue Shield (BCBS) of Colorado does have a block of small group dental risk business. Below is some data regarding that business.

COMMISSION EXPENSE

(a)	Earned premium for 2012 for Anthem BCBS of Colorado small group dental business:	$5,229,195
(b)	Incurred commissions for 2012 for Anthem BCBS small group dental business:	$550,514
(c)	Ratio of commissions to premium for 2012 for Anthem BCBS small group dental	10.53%

(d) The 10.53% commission percentage above is a result of the commissions that were paid for Anthem BCBS's small group dental business in 2012. Generally most of the products have a 10% commission for the writing agent, and there are a few agreements in place in which a managing general agent receives a commission override. So, the commission in (c) above is made up of a 10% writing agent commission and a .43% commission override.
For the new Prime Network dental products, some of the sales will be made directly by the consumer without any compensation paid to a broker or a navigator, thereby having no commission expense. With this in mind, we are expecting an average commission rate for these HCR compliant products to be sold on and off exchange to be 8%.

Anthem Blue Cross Blue Shield

ANTHEM DENTAL RATE MANUAL

Anthem Dental Pediatric/Adult/Family Products

Table of Contents

Schedule of Benefits
The following schedules of benefits will be made available to individuals depending on the member's age. Note that the schedule of benefits, for the non-participating provider benefit schedule could be different than the participating provider benefit schedule. Also, the schedule of benefits could be different for Adult members and Pediatric members.

Anthem Dental Pediatric/Adult/Family

Adult Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative*	NC or 10% to 90%
Endodontics*	NC or 10% to 90%
Periodontics*	NC or 10% to 90%
Oral Surgery*	NC or 10% to 90%
Major Restorative*	NC or 10% to 60%
Prosthetic Repairs/Adjustments*	NC or 10% to 60%
Prosthetics*	NC or 10% to 60%
Orthodontics*	NC

* NC denotes no coverage

Individual Deductible	$50 per person
Family Deductible	$50 per person
Annual Maximum	$500 - $2,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Deductible levels available at $50 at the individual level.
Annual maximum available within the range in increments of $250.
Annual Out-Of-Pocket (OOP) Maximum is not available.

Pediatric Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative	50% to 90%
Endodontics	50% to 90%
Periodontics	50% to 90%
Oral Surgery	50% to 90%
Major Restorative	50% to 60%
Prosthetic Repairs/Adjustments	50% to 60%
Prosthetics	50% to 60%
Dentally Necessary Orthodontics	50% to 60%
Cosmetic Orthodontics*	NC or 50% to 60%

* NC denotes no coverage

Individual Deductible	$50
Family Deductible	$50 per person
Annual Maximum	N/A for Participating Providers; $1,000 for Non-Participating Providers
Annual Out of Pocket Maximum Individual/Family	$700/$1,400
Dentally Necessary Orthodontics Maximum	No Maximum for Participating Providers; $1,000 LT Max for Non-Participating Providers
Cosmetic Orthodontia Lifetime Maximum	$1,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Annual Out-Of-Pocket (OOP) Maximum on Pediatric EHB plans of $700 per member up to a maximum of $1,400 per family.

Plan Options Available

- Cosmetic Orthodontia is included with the Anthem Dental Family Enhanced Plan for children age 8 up to age 19
- Annual OOP Maximum may be $1,000 per member up to a maximum of $2,000 per family

Individual Dental Rate Manual Instructions

All calculations can be completed in the following Anthem Dental Rating Worksheet (see Exhibit 1). Linear interpolation is to be followed to derive the appropriate factors for benefits not explicitly given in this rate manual.

Step 1: Fill in the benefit plan information: the Individual's name, the product selected, location, and the effective date of the contract. Note that the benefits may vary between the participating provider columns and the non-participating columns as well as between Adult and Pediatric columns. Note that 100/80/50 denotes coverage at 100% for Diagnostic and Preventive (Class I), 80% coverage for Basic Restorative (Class II), and 50% coverage for Major Restorative (Class III).

Step 2: Coinsurance Adjustment Coinsurance adjustment factors (see TABLE-1) are given for different combinations of services. Based on the plan's benefits, find the appropriate set of coinsurance adjustment factors in TABLE-1A & TABLE-1B for Pediatric and Adult benefits respectively, and enter them in the appropriate coinsurance adjustment worksheet (Exhibits 4A & 4B) and enter the results of coinsurance adjustment worksheet into the coinsurance adjustment row of the rating worksheet.

Step 3: Multiply the Adult and Pediatric starting claim cost by the appropriate coinsurance adjustment factor for each class of service. Enter the results on the line in Exhibit 1 labeled "Adjusted starting claim cost". On the line labeled "Combined claim cost" enter the sum of the Class I, Class II, and Class III adjusted starting claim costs.

Step 4: Enter the Deductible adjustment from TABLE-2. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to a deductible and that is reflected in the Pediatric starting claim costs.

Step 5: Based on the plans annual maximum benefit, enter the appropriate annual maximum adjustment factor from TABLE-3. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to an annual max and that is reflected in the Pediatric starting claim costs.

Step 6: Geographic Area Adjustment: Refer to TABLE-4, and pick the appropriate factor based on the three-digit zip code the member resides in. Enter the factor on the rating sheet.

Step 7: Annual Trend The starting claim costs were developed with a baseline date of July 1, 2012. Claim costs are expected to increase at a trend of 5.00% annually in half month increments. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$. Enter the compounded trend amount on the annual trend line on the rating worksheet. For example if the quote applies to period of January 1st, 2014 to December 31st, 2014, the trend period is from July 1st, 2012 to June 30th, 2014 (the mid-point of the rating period), or 48 half months.

Step 8: For benefit plan designs that include waiting periods for certain benefit categories, the appropriate factor in TABLE-5 will be entered in the columns on the line labeled "Benefit Waiting Period factor". For Pediatric plans, the factor is 1.00 because the Pediatric benefits are not subject to waiting periods and that is reflected in the Pediatric starting claim costs.

Step 9: Reimbursement Factor: Refer to TABLE-6, and pick the appropriate factor based on the member's three-digit zip code and enter it on the rating sheet. The same factor will be used in the in the participating provider columns and the non-participating provider columns for both Pediatric and Adult plans.

Step 10: Provider Usage Factor: Refer to TABLE-7, and enter the provider usage factors in the appropriate columns.

Step 11: Out-of-Pocket Maximum Factor: The Pediatric dental benefit has an annual Out-of-Pocket Maximum of $700 for an individual up to a limit of $1,400 for the family priced into the Pediatric dental product and has a factor of 1.00 in the rating worksheet. If a $1,000 Out-of-Pocket Maximum for an individual up to a limit of $2,000 for the family members up to the age of 19 is used, a factor of .975 is used for the Out-of-Pocket Maximum factor line in the Pediatric columns in the rating worksheet.

Step 12: Family Factor: Enter the appropriate Family Factor from TABLE-8 depending on the product that is purchased. For purchasers of an Anthem Dental Family product, the Family Factor is to account for administrative efficiencies and decreased anti-selection risk of a family purchasing instead of individual purchasers of separate Pediatric and Adult policies.

Step 13: On the line labeled "Total Claim Cost", enter the product of multiplying the combined claim cost from step 3 by the factors in steps 4 through 12.

Step 14: Retention: Enter 1 minus the retention amount from TABLE-9. The expected loss ratio for this product is 70.54% for Off-Exchange.

Step 15: On the line labeled "Gross Monthly Premium": enter the result of dividing the amount from step 13 by the amount in step 14.

Step 16: Blended Premium: To determine the blended premium rate, add the results from step 14, for the Participating Provider column, and the Non-Participating Provider column. Do this for both the Pediatric and Adult columns.

Step 17: Ortho Premium: The orthodontia premium is calculated in Exhibit 5. Dentally Necessary Orthodontia is included in all Pediatric plans and is the Pediatric class IV claim cost. This amount should be entered into the line 1 of Exhibit 5 under the Pediatric column. For the Anthem Dental Family Enhanced product, cosmetic orthodontia is included for members age 8 up to age 19 and the claim cost of the cosmetic orthodontia is located in TABLE-10 and entered in line 2 of Exhibit 5 in both the Pediatric and Adult columns. The sum of the costs for the Pediatric and Adult costs are entered in line 3 of Exhibit 5. In line 4 of Exhibit 4, enter 1 minus the retention percentage from TABLE-9. In Exhibit 5, line 5 equals

line 3 divided by line 4 to give the orthodontia premium amount to enter for the Orthodontia Premium in the rating worksheet.

Step 18: Final Premium Rates: Enter the sum of the Blended Premium Rate and Ortho Premium from step 16 and step 17 and enter into the Final Premium Rate for both the Pediatric and Adult columns.

Step 19: For the Anthem Dental Pediatric and Anthem Dental Adult products, the rates from step 18 are the rates to use multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. For the Anthem Dental Family products, Exhibit 3 is used to calculate the number of pediatric and adult premiums that will be rated for based on the makeup of the family, and the resulting values from Exhibit 3 are used in the Rating Worksheet for the Number of Pediatric Premiums and the Number of Adult Premiums, respectively. The Total Contract Premium is calculated by multiplying the rates in the Pediatric column from step 18 by the Number of Pediatric Premiums and adding the product of the Final Premium Rate in the Adult column from step 18 and the Number of Adult Premiums.

TABLE - 1A
Pediatric Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.1111	1.020	100%	2.000	1.050	100%	2.000	1.100
90%	1.0000	1.000	80%	1.600	1.041	50%	1.000	1.000
80%	0.8889	0.990	60%	1.200	1.010			
70%	0.7778	0.980	50%	1.000	1.000			

Default plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4A for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 1B
Adult Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.0000	1.000	90%	1.800	1.046	60%	1.200	1.030
90%	0.9000	0.993	80%	1.600	1.026	50%	1.000	1.000
80%	0.8000	0.992	60%	1.200	1.005	30%	0.600	0.965
75%	0.7500	0.988	50%	1.000	1.000	25%	0.500	0.955
50%	0.5000	0.970	30%	0.600	0.974	15%	0.300	0.945
			25%	0.500	0.964	0%	0.000	0.000
			15%	0.300	0.944			
			0%	0.000	0.000			

Default plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4B for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 2

Benefit Year Deductible Factors

	Factor
Deductible does not apply to Diagnostic and Preventive Services	1.00
Deductible does apply to Diagnostic and Preventive Services	0.95

Note:
A $50 per person deductible will apply to any Adult benefit set. The only variable regarding the deductible is whether or not the deductible applies to Diagnostic and Preventive Services. A $50 deductible applies to non-D&P services for Pediatric plans.

TABLE - 3

Annual Maximum Benefit Factors

Annual Maximum Amount	Factor
$500	0.9100
$750	0.9400
$1,000	0.9690
$1,200	1.0000
$1,250	1.0078
$1,500	1.0600
$1,750	1.0950
$2,000	1.1300
$2,500	1.2200

Note: For a quote that has D & P coverage only, annual maximum factors for all amounts equals amounts equals 1.00. Pediatric plans do not have an annual max therefore have a factor of 1.00 because the unlimted maximum is built into the starting claim cost.

TABLE - 4

Geographic Area Adjustment

Rating Area	Factor
Statewide	1.020

TABLE - 5

Benefit Waiting Period Factors

Services Covered	Factor
6 month waiting period on Basic Restorative and 12 month on non-D&P	0.975
12 month waiting period on Class III Only	1.000
Class I, Class II, and Class III are all covered with no waiting period	1.050

Note: Pediatric plans do not have waiting periods on non-orthodontia services therefore get a factor of 1.00.

TABLE - 6

Reimbursement Factors

Rating Area - Three-Digit Zips Included	Factor
Statewide	
Prime Network Reimbursement Factor	0.700
Non-Participating Reimbursement Factor	0.700

TABLE-7

Provider Usage Factors

Rating Area - Three-Digit Zips Included	**Factor**
Statewide	
Prime Network Usage Factor	0.507
Non-Participating Usage Factor	0.493

TABLE - 8

Family Factor

Product	**Factor**
Anthem Dental Pediatric Products	1.0000
Anthem Dental Adult Products	1.0000
Anthem Dental Family Products	0.9750

TABLE - 9

Retention Factor

	Retention as % of Premium	
	On-Exchange	Off-Exchange
Administration Expense	12.00%	12.00%
Premium Tax	1.00%	1.00%
ACA Insurer Fee	2.46%	2.46%
Exchange Fee	0.00%	0.00%
Commission	8.00%	8.00%
Profit / Risk Charge	6.00%	6.00%
Retention	**29.46%**	**29.46%**

TABLE - 10

Orthodontia Claim Costs

Orthodontia Benefit	**Claim Cost**
Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.36
Cosmetic Orthodontia per member per month cost $1,000 Lifetime Maximum with 12 Month Waiting Period Costemic Orthodontia is all orthodontia cases not deemed Dentally Necessary Orthodontia	$3.65
Dentally Necessary with no cost share for AV calculation Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.54

Exhibit 1 -- Individual Dental Rating Worksheet

Name	Product
Location (Zip Code)	Effective Date

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1												
Adjusted starting claim cost		Product of above 2 lines												
Combined Claim Cost		Sum of the 3 Classes												
Deductible adjustment		Refer to TABLE-2												
Annual maximum adjustment		Refer to TABLE-3												
Geographic area adjustment		Refer to TABLE-4												
Annual trend		Refer to Step 7												
Benefit waiting period factor		Refer to TABLE-5												
Reimbursement factor		Refer to TABLE-6												
Provider Usage factor		Refer to TABLE-10												
Out-Of-Pocket Max Factor		Refer to Step 11												
Family Factor		Refer to TABLE-8												
Total Claim Cost		Product of Combined Claims Cost factors and adjustments												
Retention	29.46%	Refer to TABLE-9	70.54%			70.54%			70.54%			70.54%		
Gross Monthly Premium		Total claim cost divided by (1 - Retention)	$0.00			$0.00			$0.00			$0.00		

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program		
Non-Participating Program		
Total	**$0.00**	**$0.00**

Ortho Premium	Refer to Exhibit 4 and Step 17	Pediatric	Adult
Total			

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total			

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total				**$0.00**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name	J. Doe
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6500	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.0200	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-10		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 4 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 3 -- Anthem Dental Family Product -- Number of Rates Worksheet

Name	J. Doe
Product	Anthem Dental Family Enhanced

Number of members in family	6
Number of non-child members (a)	2
Number of child members age 19 and older (b)	2
Number of child members under age 19 (c)	2

Number of non-child members to be rated (d):	2
Take the number (a)	
Number of children age 19 and older to be rated (e):	2
Take the lesser of (b) and 3	
Number of children age under age 19 to be rated (f)	1
Take the lesser of 3 minus (d) or (c)	

Number number of adult premiums rated	**4**
Take the sum of (d) and (e)	
Number of pediatric premiums to be rated for (f)	**1**

Exhibit 4A -- Pediatric Dental Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	90	50	50	50
3 Claim Impact Factors (Table-1)	1.111	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0200	1.0410	1.0000	1.0000
5 Total Change	1.1333	1.6656	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.6260	0.3740	1.0000
7 Total Weighted Change	1.1333	1.0427	0.3740	1.0000
8 Coinsurance Factor for Exhibit1	1.1333	1.4167		1.0000

Baseline plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 4B -- Adult Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	100	50	50	50
3 Claim Impact Factors (Table-1)	1.000	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0000	1.0260	1.0000	1.0000
5 Total Change	1.0000	1.6416	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.5283	0.4717	1.0000
7 Total Weighted Change	1.0000	0.8673	0.4717	1.0000
8 Coinsurance Factor for Exhibit1	1.0000	1.3390		1.0000

Baseline plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 5 -- Orthodontia Premium Worksheet		
Product		
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)		
Cosmetic Orthodontia (line 2)		
Total Orthodontia Claim Cost (line 3)		
Retention (line 4)		
Orthodontia Premium (line 5)		

Exhibit 6 -- Orthodontia Premium Worksheet -- Sample Calculation		
Product	Anthem Dental Family Enhanced	
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)	$0.39	$0.00
Cosmetic Orthodontia (line 2)	$3.65	$3.65
Total Orthodontia Claim Cost (line 3)	4.04	3.65
Retention (line 4)	70.54%	70.54%
Orthodontia Premium (line 5)	5.73	5.17

Exhibit 7

Development and Justification for Administrative Expense Load and Commission Load

Colorado Prime Network Products

These Prime Network dental products are administered by DeCare Dental which is a wholly owned subsidiary of WellPoint Inc. Anthem Blue Cross Blue Shield of Colorado is also a subsidiary of WellPoint Inc.

ADMINISTRATIVE EXPENSE

(a)	DeCare Dental administers a large block of small group dental risk products. Total incurred costs for administrative expenses for 2010 for the small group dental risk business administered by DeCare dental was:	$19,279,150
(b)	Total earned premium for 2010 for the small group dental risk business administered by DeCare Dental and mentioned in (a) above was:	$126,399,305
(c)	Incurred administrative costs as a percent of earned premium for 2010 for DeCare Dental's small group dental risk business was (a)/(b) which equals:	15.25%
(d)	Average annual premium per member per month (PMPM) for the small group dental business administered by DeCare Dental:	$24.43
(e)	Average monthly premium per member per month (PMPM) for the HCR compliant Prime Network business expected in Colorado:	$30.87
(f)	Ratio of average premium PMPM for DeCare small group business to expected average PMPM premium for Colorado Prime Network HCR business, equals (d) / (e):	0.791
(g)	Since the average expected Colorado dental premium is greater than the average DeCare small group dental premium, a lower percent of premium is needed to generate the needed administrative expense to operate the CO small group Prime % Complete business. That percentage is equal to (f) x (c) which equals:	12.07%

Anthem Blue Cross Blue Shield (BCBS) of Colorado does have a block of small group dental risk business. Below is some data regarding that business.

COMMISSION EXPENSE

(a)	Earned premium for 2012 for Anthem BCBS of Colorado small group dental business:	$5,229,195
(b)	Incurred commissions for 2012 for Anthem BCBS small group dental business:	$550,514
(c)	Ratio of commissions to premium for 2012 for Anthem BCBS small group dental	10.53%

(d) The 10.53% commission percentage above is a result of the commissions that were paid for Anthem BCBS's small group dental business in 2012. Generally most of the products have a 10% commission for the writing agent, and there are a few agreements in place in which a managing general agent receives a commission override. So, the commission in (c) above is made up of a 10% writing agent commission and a .43% commission override.
For the new Prime Network dental products, some of the sales will be made directly by the consumer without any compensation paid to a broker or a navigator, thereby having no commission expense. With this in mind, we are expecting an average commission rate for these HCR compliant products to be sold on and off exchange to be 8%.

Rocky Mountain Hospital and Medical Services, Inc.
Actuarial Memorandum
Anthem Dental Rate Manual

A. Summary

Reason(s) for the rate filing
This is a new rate filing.

Requested Rate Action
No rate action requested as this is a new rate filing and there is no historical data.

Marketing method(s)
This product will be marketed and sold Off Exchange by licensed brokers, via the internet and direct response to groups and individuals and their families residing in Colorado. It will be administered by DeCare Dental which is a licensed dental administrator.

Premium classification
Premiums for this product will vary by the following criteria: Benefits covered (coinsurance amounts, annual maximum benefits on adult benefits, deductibles, etc), age of the member which dictates the type of benefits available.

Product descriptions
This dental contract provides a variety of dental benefits that can be provided by an Anthem contracted provider, or a non-contracted provider. A detailed description of the benefit options may be found in the contract filing. In addition, a brief summary of the dental benefits is provided on page 2 of the rate manual portion of this rate filing.

Policy/Rider form
The memorandum address the following policy/rider forms

- Small Group policies: 13-03271.06-SG
- Individual policies: 13-03281.06-IND

Age basis
Members with an issue age below 19 will receive pediatric premiums associated with those benefits. Members with an issue age 19 and older will receive adult premiums associated with those benefits. All renewals will use the renewal age to set premiums.

Renewability provision
This product is guaranteed renewable.

B. Assumption, Acquisition or Merger

The product in this rate filing was not part of an assumption, acquisition, or merger with another company.

C. Rating Period

The rating period for this product and rate filing covers a one year period. The effective date, or the starting date, will be January 1, 2014, and the end date will be one year after the effective date. In addition, the effective date will not be before the approval date of this rate filing by the Colorado Department of Insurance.

D. Underwriting

The insured's application denotes the selected product, and effective date of coverage. An insured that cancels the Anthem dental plan cannot re-enroll for two years.

E. Effect of Law Changes

Not Applicable

F. Rate History

This is a new product and a new rate filing, therefore there is no prior rate history.

G. Coordination of Benefits

All coordination of benefit savings has been reflected in the baseline starting claims cost.

H. Relation of Benefits to Premium

The premiums are determined by developing the claims costs based on benefit design and group or individual's demographics and then dividing that number by the 1 minus the retention. TABLE-9 (given below) details each specific component of the retention load. These expenses are based on anticipated needs of Colorado-specific business. The anticipated retention is 29.46% and therefore the loss ratio is 70.54% which is well above the minimum of 60% set forth in CO regulation 4-24-11, section 6.H.3.b.

Retention Components	**Off-Exchange**	**Explanation**
Administration Expense	12.00%	*See Exhibit 7
Premium Tax	1.00%	CO Statute
ACA Insurer Fee	2.46%	Federal Fee
Exchange Fee	0.00%	0 cost
Commission	8.00%	*See Exhibit 7
Profit / Contingency	6.00%	*See Section J
Retention	**29.46%**	

I. Lifetime Loss Ratio

The products included in this rate filing were not priced using a lifetime loss ratio standard.

J. Provision for Profit and Contingencies

The Provision for Profit and Contingencies is set at 6% - below the 7% maximum outlined in CO regulation 4-24-11, section 6.J. This 6% is factored into retention to allow for accumulation of fund surplus and reserves necessary for Anthem BCBS to have adequate funds on hand to provide for unexpected claim volatility and fluctuations.

K. Complete Explanation as to How the Proposed Rates were Determined

Please refer to the the Dental Rate Manual that is attached to this memorandum

L. Trend

The starting claim costs were developed for an effective mid-point date of July 1st, 2012. The trend formula is (1 + (trend %/100))^ ((mid-point of rating period – July 1, 2012 expressed in integer half months)/24). Starting July 1st, 2012, claim costs are expected to increase at a trend of 5.00% annually in half-month increments. Premium rates will be guaranteed for 12 months, but for purposes of new sales, will change annually using the middle of the rating period to calculate the trend amount. For example, the January 1st, 2014 to December 31st, 2014 uses a rating period midpoint of June 30th, 2014 in calculating the trend amount.

The 5% projected trend assumption is composed of the following 3 components

- Utilization: 1.5% increase in services per exposure because of the expectation that the influx of previously uninsured will utilize more than the average person in year 1
- Unit cost: 2.0% increase in allowed charges from dental providers because the dental CPI is forecasted to increase more than 3% due to economic improvements and pent up demand to increase prices – this will mostly impact the non-participating provider
- Service Mix: 1.5% increase due to influx of the uninsured that will need more intense (Basic) services than the average policyholders.

Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. The membership steadily grew until 2013 and is starting to level off. As a result of the changing membership, the claim trends do not increase as one would expect because the new membership are selecting plans that have benefits that are less rich. As noted above, we do expect that the membership for Anthem Dental Adult / Pediatric will likely have a lot of pent up demand.

Table L.1

Statistics by Incurred Year

Year	Period	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Net Trend
2010	Starts Apr	4,692	9,009	$241,048	$241,048	$0	1,330	n/a
2011	CY	20,830	40,269	$896,589	$896,589	$0	5,268	-16.8%
2012	CY	38,783	74,929	$1,560,407	$1,556,209	$4,198	9,535	-6.5%
2013	YTD June	22,268	42,983	$863,043	$794,465	$68,577	4,949	-3.6%
All	Total	**86,573**	**167,190**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	

Table L.2

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Month

Year	Month	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts
2010	1	0	0	$0	$0	$0	0
2010	2	0	0	$0	$0	$0	0
2010	3	0	0	$0	$0	$0	0
2010	4	64	148	$4,117	$4,117	$0	22
2010	5	242	448	$11,792	$11,792	$0	60
2010	6	298	556	$12,270	$12,270	$0	76
2010	7	399	743	$19,910	$19,910	$0	116
2010	8	474	905	$22,930	$22,930	$0	134
2010	9	592	1,147	$27,856	$27,856	$0	167
2010	10	730	1,437	$37,886	$37,886	$0	202
2010	11	849	1,655	$43,918	$43,918	$0	234
2010	12	1,044	1,970	$60,369	$60,369	$0	319
2011	1	1,314	2,560	$49,817	$49,817	$0	293
2011	2	1,431	2,799	$57,388	$57,388	$0	357
2011	3	1,517	2,965	$75,785	$75,785	$0	440
2011	4	1,566	3,035	$65,564	$65,564	$0	382
2011	5	1,639	3,158	$76,557	$76,557	$0	442
2011	6	1,654	3,202	$78,525	$78,525	$0	468
2011	7	1,729	3,375	$81,911	$81,911	$0	450
2011	8	1,820	3,532	$93,680	$93,680	$0	557
2011	9	1,882	3,622	$63,690	$63,690	$0	386
2011	10	1,972	3,768	$71,239	$71,239	$0	431
2011	11	2,063	3,962	$80,260	$80,260	$0	480
2011	12	2,243	4,291	$102,173	$102,173	$0	582
2012	1	2,699	5,185	$122,698	$122,666	$32	688
2012	2	2,810	5,419	$112,787	$112,751	$36	701
2012	3	2,892	5,608	$116,880	$116,834	$46	731
2012	4	2,961	5,743	$115,993	$115,924	$70	711
2012	5	3,016	5,832	$113,131	$113,040	$91	746
2012	6	3,092	5,978	$123,423	$123,278	$145	777
2012	7	3,275	6,351	$127,931	$127,724	$207	769
2012	8	3,386	6,557	$148,147	$147,819	$328	908
2012	9	3,437	6,637	$129,136	$128,724	$412	823
2012	10	3,614	6,952	$146,397	$145,760	$637	915
2012	11	3,717	7,154	$152,312	$151,388	$924	899
2012	12	3,884	7,513	$151,572	$150,302	$1,270	867
2013	1	3,869	7,461	$171,506	$169,501	$2,005	979
2013	2	3,849	7,392	$143,835	$141,496	$2,338	828
2013	3	3,785	7,266	$142,227	$138,727	$3,499	897
2013	4	3,786	7,294	$145,004	$138,480	$6,523	871
2013	5	3,583	6,982	$133,282	$122,013	$11,269	782
2013	6	3,396	6,588	$127,189	$84,248	$42,941	592

M. Credibility

This product is new and thus does not have any experience. So, we used a similar product's information displayed in section N. This data is fully credible since there are more than 2,000 life years (24,000 members months) and 2,000 claims –totals are in Table N.1 in Section N.

N. Data Requirements

This is a new product and thus there are no earned premiums, incurred claims, actual benefits ratios, number of claims, average covered lives and number of policyholders to submit on a Colorado-only basis for at least 3 years. Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. Below is the yearly summary.

Table N.1

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Year

													Average	
Year	Period	Subscriber Months	Member Months	Billed Premium	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Loss Ratio	Premium PMPM	Incurred PMPM	Net Trend	Subscribers	Members
2010	Starts Apr	4,692	9,009	$294,677	$241,048	$241,048	$0	1,330	82%	$32.71	$26.76	n/a	616	1,183
2011	CY	20,830	40,269	$1,288,819	$896,589	$896,589	$0	5,268	70%	$32.01	$22.26	-16.8%	1,872	3,608
2012	CY	38,783	74,929	$2,428,330	$1,560,407	$1,556,209	$4,198	9,535	64%	$32.41	$20.83	-6.5%	3,424	6,614
2013	YTD June	22,268	42,983	$1,389,503	$863,043	$794,465	$68,577	4,949	62%	$32.33	$20.08	-3.6%	3,636	7,031
All	Total	**86,573**	**167,190**	**$5,401,329**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	**66%**	**$32.31**	**$21.30**			

O. Side-by-Side Comparison

This is a new product and thus there is nothing that can be compared.

P. Benefits Ratio Projections

The following is the 2014 projection of incurred claims, revenue and benefit loss ratios. Note that this is a new filing and there is no rate change request –that's why there are zeroes in the "Without Change" section.

Table P.1

	With Change			Without Change		
Date	**Prem**	**Clms**	**LR**	**Prem**	**Clms**	**LR**
1/1/2014	$459,985	$335,581	73%	$0	$0	n/a
2/1/2014	$633,483	$396,456	63%	$0	$0	n/a
3/1/2014	$797,830	$526,635	66%	$0	$0	n/a
4/1/2014	$825,590	$557,156	67%	$0	$0	n/a
5/1/2014	$822,762	$525,419	64%	$0	$0	n/a
6/1/2014	$820,104	$540,782	66%	$0	$0	n/a
7/1/2014	$821,525	$543,676	66%	$0	$0	n/a
8/1/2014	$819,824	$524,673	64%	$0	$0	n/a
9/1/2014	$819,182	$495,312	60%	$0	$0	n/a
10/1/2014	$820,334	$526,982	64%	$0	$0	n/a
11/1/2014	$818,546	$460,460	56%	$0	$0	n/a
12/1/2014	$843,376	$622,756	74%	$0	$0	n/a

Q. Other Factors

Please refer to the information below and the Dental Rate Manual that is attached to this memorandum.

Proposed Premium Rates PMPM

The rates to use (in Table Q.1) multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. The propose premium rates are on per member per month (PMPM) basis.

Table Q.1

		Premium PMPM			
		70 % AV		85% AV	
CO Product IDs	Description of Product	Adult	Pediatric	Adult	Pediatric
87269CO113	SG PPO Pediatric Dental Off Exchange		$17.90		$20.92
87269CO114	SG PPO Adult Dental Off Exchange	$24.93		$33.17	
87269CO115	SG PPO Family Dental Off Exchange	$24.31	$17.46	$37.52	$25.58
87269CO116	Individual PPO Pediatric Dental Off Exchange		$17.90		$20.92
87269CO117	Individual PPO Adult Dental Off Exchange	$24.93		$33.17	
87269CO118	Individual PPO Family Dental Off Exchange	$24.31	$17.46	$37.52	$25.58

The purpose of this filing is to demonstrate compliance with minimum requirements of the state of Colorado and show that the benefits are reasonable in relation to premiums charged.

This Anthem Blue Cross and Blue Shield (Anthem BCBS) Anthem Dental Rate Manual applies to the Anthem Dental Pediatric/Adult/Family products which are HCR compliant. This rate manual applies to rates that are being used and developed on behalf of Rocky Mountain Hospital and Medical Services, Inc, also doing business as Anthem BCBS. This rate manual applies to Small Group policies 13-03271.06-SG, Individual policies and 13-03281.06-IND. Individuals will be able to select plans with a range of benefit design options. This rate manual and the rates developed by it will be effective January 1st, 2014.

The rating method begins with starting claim costs. Factors are then applied to these costs that develop rates based on the member's benefit plan. The methodology will use linear interpolation to derive the appropriate factors for benefits not explicitly stated in this rate manual. The rating steps are shown in the two rating worksheets in the back of the Anthem BCBS Anthem Dental Rate Manual. Exhibit 1 shows the rating worksheet template, and Exhibit 2 shows a sample rate calculation.

Definitions

Class of Dental Services
Class I – Diagnostic and Preventive
Class II – Basic services; simple restorations, periodontics, endodontics and oral surgery
Class III – Major restorative services; prosthodontics and prosthetics
Class IV – Orthodontics; Dentally Necessary Orthodontics

Pediatric – Pediatric EHB Mandated Dental Benefits for individuals up to the age of 19
Adult – Dental Benefits for individuals age 19 and over
Family – Pediatric and Adult benefits purchased as a single contract. Individuals up to the age of 19 receive Pediatric benefits and individuals age 19 and over receive Adult benefits.
AV – Actuarial Value measured using benefits when using a participating provider represents the percentage of costs covered by the plan

Plan Offerings

Anthem Dental Pediatric Plan – Pediatric dental benefit with 70% AV
Anthem Dental Pediatric Enhanced Plan – Pediatric dental benefit with 85% AV
Anthem Dental Adult Plan – Adult dental benefit
Anthem Dental Adult Enhanced Plan – Adult dental benefit with higher coinsurance levels
Anthem Dental Family Plan – A combination of Anthem Dental Pediatric Plan and Anthem Dental Adult Plan with benefits based on the age of family members
Anthem Dental Family Enhanced Plan – A combination of Anthem Dental Pediatric Enhanced Plan and Anthem Dental Adult Enhanced Plan with benefits based on the age of family members; includes cosmetic orthodontia for children from age 8 up to age 19

Morbidity

The starting claim cost for each class of service (Diagnostic & Preventive, Basic, Major, and Orthodontics) is based on analyses of several recent years of claim data. An extensive claim database was used to derive this experience. This data is supplemented as needed by data provided by Milliman USA, an Actuarial Consulting firm.

Analyses were conducted separately for each of the following services: diagnostic and preventive, basic restorative, periodontic, endodontic, oral surgery, major restorative, prosthodontics, prosthetic repairs and orthodontics. The results were then aggregated into Class I, Class II, Class III and Class IV services.

The starting claim costs are developed assuming reimbursement at the full amount of the dentist submitted charge, where the dentist submitted charge is equal to a national average. The starting claim costs experience has a midpoint date of July 1, 2012.

The monthly starting Pediatric and Adult benefit claim costs are:

	Pediatric	Adult
Class I Diagnostic and Preventive Services	$13.10	$19.29
Class II Basic Services	$ 3.85	$11.79
Class III Major Services	$ 0.17	$ 8.25
Class IV Orthodontic Services	$ 0.39	$ 0.00

The Adult plans starting claim costs assume coinsurance levels of 100% for Class I services, 50% for Class II services, 50% for Class III services, a $50 per person deductible and a $1,200 annual maximum. The specific procedures defined by the PPACA Stand-Alone Dental Plan Procedures for Colorado dated May 31, 2013 are the only procedures covered in the Pediatric starting claim costs. The Pediatric starting claim costs assume coinsurance levels of 90% for Class I services, 50% for Class II services, 50% for Class III services, and also include Class IV Orthodontic Services as Dentally Necessary Orthodontia assuming a coinsurance level of 50%. All Pediatric plan starting claim costs assume no annual maximum and an out-of-pocket maximum of $700 per member up to a maximum of $1,400 per family. The pediatric plans also include a $50 deductible for non-Diagnostic & Preventive services which is included in the starting claim costs. TABLE-1 (see Rate Manual for Tables TABLE-1 through TABLE-10 referenced in this Actuarial Memorandum) lists the coinsurance percentages being offered and their corresponding adjustment factors for each of the three classes of services to reflect the differences from the coinsurance levels used to establish the starting claim costs. Due to the out-of-pocket maximum on the pediatric benefit, Class IV claim costs will not change with varying coinsurance.

Pediatric EHB Actuarial Value

The model used to develop the Actuarial Value (AV) for the pediatric EHB plans was comprised of dental claims data of members under the age of 19. The data was used to develop annual utilization by procedure code for all covered services under the pediatric EHB while including utilization adjustments for non-traditional benefits such as no annual max and an annual out-of-pocket maximum. Average allowed amounts by procedure were used to establish a total claim costs by benefit category for In-Network claims. Coinsurance levels where then determined by benefit category, defined as Class I through Class V in the preceding paragraph, and the ratio of the resulting claim costs with coinsurance to the total claim costs with 100% coverage is then verified to be within the AV of 70% plus or minus 2% or 85% plus or minus 2%.

Actuarial Value Calculation

The Actuarial Value (AV) calculation is determined as the ratio of the EHB claim costs of a certain benefit set in comparison to the claim costs of 100% coverage of the same benefits for In Network providers. The starting claim costs are adjusted for necessary coinsurance adjustments by pediatric benefit class using Table 1A. The table below shows the AV calculation for the Anthem Dental Pediatric Plans.

Benefit Class	Starting Claim Cost	Anthem Dental Pediatric	Anthem Dental Pediatric Enhanced	100% Coverage w/no deductible
Class I	$13.10	$13.10	$14.85	$15.31
Class II	$3.85	$3.85	$5.45	$8.34
Class III	$0.17	$0.17	$0.17	$0.39
Class IV	$0.36	$0.36	$0.36	$0.54
Total Claim Cost	$17.48	$17.48	$20.83	$24.57
Actuarial Value		**71.2%**	**84.8%**	

Mortality

Not Applicable

Persistency

Not Applicable

Premium Modalization Rules

Not Applicable

Claim Liability and Reserves

Incurred but not paid (IBNP) reserves which includes an amount for claim amounts reported but not yet paid will be established using a lag factor approach. This method uses claim payment histories to estimate the amount of claims that have been incurred in a particular time period. From the incurred amount, the actual paid amount is subtracted to get the IBNP reserve.

Active Life Reserves

Not Applicable, there are no active life reserves for this product.

Coinsurance Adjustment

Coinsurance amounts may be equal for benefits provided by participating providers, or they may differ depending on whether the member gets services from a participating or a non-participating provider. Additionally, coinsurance amounts may differ between Pediatric and Adult plans. To determine the coinsurance adjustment factors that apply to a given product option, refer to TABLE-1.

Deductible Adjustment

Deductibles, if present, are $50 per person per benefit year. Deductible factors are applied to Adult plan claim costs. The benefit year deductible can either apply to diagnostic and preventive services, or it can be waived for diagnostic and preventive services. Factors for the two deductible options are found in TABLE-2. Pediatric plans are subject to a $50 deductible on non-Class I services.

Annual Maximum Adjustment

The annual maximum for each person can be between $500 and $2,000 per benefit year. Adjustment factors are shown in TABLE-3. Pediatric benefits do not have an annual maximum amount on participating provider benefits and a $1,000 annual max on non-participating provider benefits which is reflective in the Pediatric starting claim costs.

Dependent Age Adjustment

Dependents are children of the individual. All product options assume that children of enrolled individuals are covered up to age 26, regardless if they are a student or not.

If the dependent child is under the age of 19, they will have a Pediatric EHB dental benefit plan design. If the dependent child is between the ages of 19 up to age 26, they will receive an Adult dental benefit plan design. Dependent coverage up to age 26 is assumed in the starting claims cost, so no claim factors are needed for this pricing assumption.

Geographic Area Adjustment

Anthem BCBS only markets to individuals who reside in the state of Colorado. This rating model does not use different geographic areas within Colorado, therefore the rates developed in this model are used for the entire state of Colorado. Given that rates apply to the entire state, one geographic area adjustment factor is used for all rates.

The Geographic Area Adjustment varies by rating area and is in TABLE-4.

Occupational Adjustment

An occupational adjustment factor is not used in this rating model.

Prior Coverage

These Anthem Dental products may have waiting periods for Class II and Class III services for Adult plans, as discussed below. In some circumstances, if the individual purchaser has had prior comparable coverage, waiting periods will be waived. However, prior coverage is not a pricing variable used in the pricing model. There is no waiting period for Pediatric EHB benefits.

Benefit waiting period factor

Certain Adult plans may have waiting periods before certain categories of services will be covered under the plan. These waiting periods can apply to basic services, major services. If applicable, the waiting period for basic services will be 6 months, and the waiting period for major services will be 12 months. For purposes of waiting periods, Endodontic, Periodontic, and Oral Surgery services are included in major services and have a 12 month waiting period. The Pediatric EHB benefit does not have any waiting periods on services other than dentally necessary orthodontia, which has a 12 month waiting period which is figured into the

orthodontia starting claim cost. The appropriate adjustment for claims cost can be found in TABLE-5.

Reimbursement

The assumed level of provider reimbursement in the starting claims cost is set at the average of national dental submitted charges. The allowed reimbursement for the Anthem Dental Pediatric/Adult/Family products are the same whether or not the member sees a participating provider or a non-participating provider. The reimbursement adjustment factors for the Anthem Dental Pediatric/Adult/Family products are found in TABLE-6.

Orthodontia

Dentally necessary orthodontia is part of the Pediatric EHB benefit. When a non-participating provider is used, there is a $1,000 Lifetime Maximum benefit. There is no Lifetime Maximum benefit when a participating provider is used. Supplemental cosmetic child orthodontia is included for family purchasers that select the Anthem Dental Family Enhanced Plan for child dependents age 8 up to age 19.

Retention

Retention is a percentage of gross premiums and includes administrative expense, profit and Contingency, and premium tax as required. The retention table is shown in TABLE-9. The retention also includes provision for a writing agent commission as well as a commission override if applicable. The retention breakout differs between products sold Off-Exchange, however the total retention is equivalent to achieve the same price as shown in TABLE-9.

Expected Loss Ratio

The expected loss ratio for this product is 70.54%. This equals 100% less the retention percentage.

Premium

The Anthem Dental Rating Worksheet (Exhibit 1) yields per member per month rates. The maximum number of child dependents that premiums would be collected for is three as determined by Exhibit 3. The premium for the Anthem Dental Family product is the sum of the individual premiums of the Pediatric and Adult benefits multiplied by the Family Factor.

Provider Usage Factor

The Anthem Dental Pediatric/Adult/Family products use the Anthem Prime network. Provider usage factors for the Anthem Dental Pediatric/Adult/Family products are shown in TABLE-7. The factor which applies to participating providers, and the inverse, which applies to non-participating providers, will be applied respectively to determine the Participating Provider premium and the Non-Participating premium in the Rating Worksheet. The final premium rate is then the sum of the premiums for the participating provider benefits and the non-participating provider benefits.

To the best of my knowledge, this rate filing is in compliance with applicable laws and regulations of the state of Colorado, and with the rules of the Department of Insurance. I certify that the rates are not excessive, inadequate or unfairly discriminatory. I also certify that the rates are reasonable in relation to the benefits provided. The actuarial methods, considerations and analysis used in forming my opinion conform to the relevant Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

Robert L Mikkel

7/19/13

Robert L. Mikkelsen, F.S.A., M.A.A.A.
Actuary

Date

Rocky Mountain Hospital and Medical Services, Inc.
Actuarial Memorandum
Anthem Dental Rate Manual

A. Summary

Reason(s) for the rate filing
This is a new rate filing.

Requested Rate Action
No rate action requested as this is a new rate filing and there is no historical data.

Marketing method(s)
This product will be marketed and sold On Exchange by licensed brokers, via the internet and direct response to groups and individuals and their families residing in Colorado. It will be administered by DeCare Dental which is a licensed dental administrator.

Premium classification
Premiums for this product will vary by the following criteria: Benefits covered (coinsurance amounts, annual maximum benefits on adult benefits, deductibles, etc), age of the member which dictates the type of benefits available.

Product descriptions
This dental contract provides a variety of dental benefits that can be provided by an Anthem contracted provider, or a non-contracted provider. A detailed description of the benefit options may be found in the contract filing. In addition, a brief summary of the dental benefits is provided on page 2 of the rate manual portion of this rate filing.

Policy/Rider form
The memorandum address the following policy/rider forms

- Small Group policies: 13-03271.06-SG-EX
- Individual policies: 13-03281.06-IND-EX

Age basis
Members with an issue age below 19 will receive pediatric premiums associated with those benefits. Members with an issue age 19 and older will receive adult premiums associated with those benefits. All renewals will use the renewal age to set premiums.

Renewability provision
This product is guaranteed renewable.

B. Assumption, Acquisition or Merger

The product in this rate filing was not part of an assumption, acquisition, or merger with another company.

C. Rating Period

The rating period for this product and rate filing covers a one year period. The effective date, or the starting date, will be January 1, 2014, and the end date will be one year after the effective date. In addition, the effective date will not be before the approval date of this rate filing by the Colorado Department of Insurance.

D. Underwriting

The insured's application denotes the selected product, and effective date of coverage. An insured that cancels the Anthem dental plan cannot re-enroll for two years.

E. Effect of Law Changes

Not Applicable

F. Rate History

This is a new product and a new rate filing, therefore there is no prior rate history.

G. Coordination of Benefits

All coordination of benefit savings has been reflected in the baseline starting claims cost.

H. Relation of Benefits to Premium

The premiums are determined by developing the claims costs based on benefit design and group or individual's demographics and then dividing that number by the 1 minus the retention. TABLE-9 (given below) details each specific component of the retention load. These expenses are based on anticipated needs of Colorado-specific business. The anticipated retention is 29.46% and therefore the loss ratio is 70.54% which is well above the minimum of 60% set forth in CO regulation 4-24-11, section 6.H.3.b.

Retention Components	**On-Exchange**	**Explanation**
Administration Expense	12.00%	*See Exhibit 7
Premium Tax	1.00%	CO Statute
ACA Insurer Fee	2.46%	Federal Fee
Exchange Fee	0.00%	0 cost
Commission	8.00%	See Exhibit 7
Profit / Contingency	6.00%	*See Section J
Retention	**29.46%**	

I. Lifetime Loss Ratio

The products included in this rate filing were not priced using a lifetime loss ratio standard.

J. Provision for Profit and Contingencies

The Provision for Profit and Contingencies is set at 6% - below the 7% maximum outlined in CO regulation 4-24-11, section 6.J. This 6% is factored into retention to allow for accumulation of fund surplus and reserves necessary for Anthem BCBS to have adequate funds on hand to provide for unexpected claim volatility and fluctuations.

K. Complete Explanation as to How the Proposed Rates were Determined

Please refer to the the Dental Rate Manual that is attached to this memorandum

L. Trend

The starting claim costs were developed for an effective mid-point date of July 1st, 2012. The trend formula is (1 + (trend %/100))^ ((mid-point of rating period – July 1, 2012 expressed in integer half months)/24). Starting July 1st, 2012, claim costs are expected to increase at a trend of 5.00% annually in half-month increments. Premium rates will be guaranteed for 12 months, but for purposes of new sales, will change annually using the middle of the rating period to calculate the trend amount. For example, the January 1st, 2014 to December 31st, 2014 uses a rating period midpoint of June 30th, 2014 in calculating the trend amount.

The 5% projected trend assumption is composed of the following 3 components

- Utilization: 1.5% increase in services per exposure because of the expectation that the influx of previously uninsured will utilize more than the average person in year 1
- Unit cost: 2.0% increase in allowed charges from dental providers because the dental CPI is forecasted to increase more than 3% due to economic improvements and pent up demand to increase prices – this will mostly impact the non-participating provider
- Service Mix: 1.5% increase due to influx of the uninsured that will need more intense (Basic) services than the average policyholders.

Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. The membership steadily grew until 2013 and is starting to level off. As a result of the changing membership, the claim trends do not increase as one would expect because the new membership are selecting plans that have benefits that are less rich. As noted above, we do expect that the membership for Anthem Dental Adult / Pediatric will likely have a lot of pent up demand.

Table L.1

Statistics by Incurred Year

Year	Period	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Net Trend
2010	Starts Apr	4,692	9,009	$241,048	$241,048	$0	1,330	n/a
2011	CY	20,830	40,269	$896,589	$896,589	$0	5,268	-16.8%
2012	CY	38,783	74,929	$1,560,407	$1,556,209	$4,198	9,535	-6.5%
2013	YTD June	22,268	42,983	$863,043	$794,465	$68,577	4,949	-3.6%
All	Total	**86,573**	**167,190**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	

Table L.2

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Month

Year	Month	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts
2010	1	0	0	$0	$0	$0	0
2010	2	0	0	$0	$0	$0	0
2010	3	0	0	$0	$0	$0	0
2010	4	64	148	$4,117	$4,117	$0	22
2010	5	242	448	$11,792	$11,792	$0	60
2010	6	298	556	$12,270	$12,270	$0	76
2010	7	399	743	$19,910	$19,910	$0	116
2010	8	474	905	$22,930	$22,930	$0	134
2010	9	592	1,147	$27,856	$27,856	$0	167
2010	10	730	1,437	$37,886	$37,886	$0	202
2010	11	849	1,655	$43,918	$43,918	$0	234
2010	12	1,044	1,970	$60,369	$60,369	$0	319
2011	1	1,314	2,560	$49,817	$49,817	$0	293
2011	2	1,431	2,799	$57,388	$57,388	$0	357
2011	3	1,517	2,965	$75,785	$75,785	$0	440
2011	4	1,566	3,035	$65,564	$65,564	$0	382
2011	5	1,639	3,158	$76,557	$76,557	$0	442
2011	6	1,654	3,202	$78,525	$78,525	$0	468
2011	7	1,729	3,375	$81,911	$81,911	$0	450
2011	8	1,820	3,532	$93,680	$93,680	$0	557
2011	9	1,882	3,622	$63,690	$63,690	$0	386
2011	10	1,972	3,768	$71,239	$71,239	$0	431
2011	11	2,063	3,962	$80,260	$80,260	$0	480
2011	12	2,243	4,291	$102,173	$102,173	$0	582
2012	1	2,699	5,185	$122,698	$122,666	$32	688
2012	2	2,810	5,419	$112,787	$112,751	$36	701
2012	3	2,892	5,608	$116,880	$116,834	$46	731
2012	4	2,961	5,743	$115,993	$115,924	$70	711
2012	5	3,016	5,832	$113,131	$113,040	$91	746
2012	6	3,092	5,978	$123,423	$123,278	$145	777
2012	7	3,275	6,351	$127,931	$127,724	$207	769
2012	8	3,386	6,557	$148,147	$147,819	$328	908
2012	9	3,437	6,637	$129,136	$128,724	$412	823
2012	10	3,614	6,952	$146,397	$145,760	$637	915
2012	11	3,717	7,154	$152,312	$151,388	$924	899
2012	12	3,884	7,513	$151,572	$150,302	$1,270	867
2013	1	3,869	7,461	$171,506	$169,501	$2,005	979
2013	2	3,849	7,392	$143,835	$141,496	$2,338	828
2013	3	3,785	7,266	$142,227	$138,727	$3,499	897
2013	4	3,786	7,294	$145,004	$138,480	$6,523	871
2013	5	3,583	6,982	$133,282	$122,013	$11,269	782
2013	6	3,396	6,588	$127,189	$84,248	$42,941	592

M. Credibility

This product is new and thus does not have any experience. So, we used a similar product's information displayed in section N. This data is fully credible since there are more than 2,000 life years (24,000 members months) and 2,000 claims –totals are in Table N.1 in Section N.

N. Data Requirements

This is a new product and thus there are no earned premiums, incurred claims, actual benefits ratios, number of claims, average covered lives and number of policyholders to submit on a Colorado-only basis for at least 3 years. Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. Below is the yearly summary.

Table N.1

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Year

													Average	
Year	Period	Subscriber Months	Member Months	Billed Premium	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Loss Ratio	Premium PMPM	Incurred PMPM	Net Trend	Subscribers	Members
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O. Side-by-Side Comparison

This is a new product and thus there is nothing that can be compared.

P. Benefits Ratio Projections

The following is the 2014 projection of incurred claims, revenue and benefit loss ratios. Note that this is a new filing and there is no rate change request –that's why there are zeroes in the "Without Change" section.

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	With Change			Without Change		
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5/1/2014	$822,762	$525,419	64%	$0	$0	n/a
6/1/2014	$820,104	$540,782	66%	$0	$0	n/a
7/1/2014	$821,525	$543,676	66%	$0	$0	n/a
8/1/2014	$819,824	$524,673	64%	$0	$0	n/a
9/1/2014	$819,182	$495,312	60%	$0	$0	n/a
10/1/2014	$820,334	$526,982	64%	$0	$0	n/a
11/1/2014	$818,546	$460,460	56%	$0	$0	n/a
12/1/2014	$843,376	$622,756	74%	$0	$0	n/a

Q. Other Factors

Please refer to the information below and the Dental Rate Manual that is attached to this memorandum.

Proposed Premium Rates PMPM

The rates to use (in Table Q.1) multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. The propose premium rates are on per member per month (PMPM) basis.

Table Q.1

		Premium PMPM			
		70 % AV		85% AV	
CO Product IDs	Description of Product	Adult	Pediatric	Adult	Pediatric
87269CO107	SG PPO Pediatric Dental On Exchange		$17.90		$20.92
87269CO108	SG PPO Adult Dental On Exchange	$24.93		$33.17	
87269CO109	SG PPO Family Dental On Exchange	$24.31	$17.46	$37.52	$25.58
87269CO110	Individual PPO Pediatric Dental On Exchange		$17.90		$20.92
87269CO111	Individual PPO Adult Dental On Exchange	$24.93		$33.17	
87269CO112	Individual PPO Family Dental On Exchange	$24.31	$17.46	$37.52	$25.58

The purpose of this filing is to demonstrate compliance with minimum requirements of the state of Colorado and show that the benefits are reasonable in relation to premiums charged.

This Anthem Blue Cross and Blue Shield (Anthem BCBS) Anthem Dental Rate Manual applies to the Anthem Dental Pediatric/Adult/Family products which are HCR compliant. This rate manual applies to rates that are being used and developed on behalf of Rocky Mountain Hospital and Medical Services, Inc, also doing business as Anthem BCBS. This rate manual applies to Small Group policies 13-03271.06-SG-EX &, Individual policies 13-03281.06-IND-EX,. Individuals will be able to select plans with a range of benefit design options. This rate manual and the rates developed by it will be effective January 1st, 2014.

The rating method begins with starting claim costs. Factors are then applied to these costs that develop rates based on the member's benefit plan. The methodology will use linear interpolation to derive the appropriate factors for benefits not explicitly stated in this rate manual. The rating steps are shown in the two rating worksheets in the back of the Anthem BCBS Anthem Dental Rate Manual. Exhibit 1 shows the rating worksheet template, and Exhibit 2 shows a sample rate calculation.

Definitions

Class of Dental Services
Class I – Diagnostic and Preventive
Class II – Basic services; simple restorations, periodontics, endodontics and oral surgery
Class III – Major restorative services; prosthodontics and prosthetics
Class IV – Orthodontics; Dentally Necessary Orthodontics

Pediatric – Pediatric EHB Mandated Dental Benefits for individuals up to the age of 19
Adult – Dental Benefits for individuals age 19 and over
Family – Pediatric and Adult benefits purchased as a single contract. Individuals up to the age of 19 receive Pediatric benefits and individuals age 19 and over receive Adult benefits.
AV – Actuarial Value measured using benefits when using a participating provider represents the percentage of costs covered by the plan

Plan Offerings

Anthem Dental Pediatric Plan – Pediatric dental benefit with 70% AV
Anthem Dental Pediatric Enhanced Plan – Pediatric dental benefit with 85% AV
Anthem Dental Adult Plan – Adult dental benefit
Anthem Dental Adult Enhanced Plan – Adult dental benefit with higher coinsurance levels
Anthem Dental Family Plan – A combination of Anthem Dental Pediatric Plan and Anthem Dental Adult Plan with benefits based on the age of family members
Anthem Dental Family Enhanced Plan – A combination of Anthem Dental Pediatric Enhanced Plan and Anthem Dental Adult Enhanced Plan with benefits based on the age of family members; includes cosmetic orthodontia for children from age 8 up to age 19

Morbidity

The starting claim cost for each class of service (Diagnostic & Preventive, Basic, Major, and Orthodontics) is based on analyses of several recent years of claim data. An extensive claim database was used to derive this experience. This data is supplemented as needed by data provided by Milliman USA, an Actuarial Consulting firm.

Analyses were conducted separately for each of the following services: diagnostic and preventive, basic restorative, periodontic, endodontic, oral surgery, major restorative, prosthodontics, prosthetic repairs and orthodontics. The results were then aggregated into Class I, Class II, Class III and Class IV services.

The starting claim costs are developed assuming reimbursement at the full amount of the dentist submitted charge, where the dentist submitted charge is equal to a national average. The starting claim costs experience has a midpoint date of July 1, 2012.

The monthly starting Pediatric and Adult benefit claim costs are:

	Pediatric	Adult
Class I Diagnostic and Preventive Services	$13.10	$19.29
Class II Basic Services	$ 3.85	$11.79
Class III Major Services	$ 0.17	$ 8.25
Class IV Orthodontic Services	$ 0.39	$ 0.00

The Adult plans starting claim costs assume coinsurance levels of 100% for Class I services, 50% for Class II services, 50% for Class III services, a $50 per person deductible and a $1,200 annual maximum. The specific procedures defined by the PPACA Stand-Alone Dental Plan Procedures for Colorado dated May 31, 2013 are the only procedures covered in the Pediatric starting claim costs. The Pediatric starting claim costs assume coinsurance levels of 90% for Class I services, 50% for Class II services, 50% for Class III services, and also include Class IV Orthodontic Services as Dentally Necessary Orthodontia assuming a coinsurance level of 50%. All Pediatric plan starting claim costs assume no annual maximum and an out-of-pocket maximum of $700 per member up to a maximum of $1,400 per family. The pediatric plans also include a $50 deductible for non-Diagnostic & Preventive services which is included in the starting claim costs. TABLE-1 (see Rate Manual for Tables TABLE-1 through TABLE-10 referenced in this Actuarial Memorandum) lists the coinsurance percentages being offered and their corresponding adjustment factors for each of the three classes of services to reflect the differences from the coinsurance levels used to establish the starting claim costs. Due to the out-of-pocket maximum on the pediatric benefit, Class IV claim costs will not change with varying coinsurance.

Pediatric EHB Actuarial Value

The model used to develop the Actuarial Value (AV) for the pediatric EHB plans was comprised of dental claims data of members under the age of 19. The data was used to develop annual utilization by procedure code for all covered services under the pediatric EHB while including utilization adjustments for non-traditional benefits such as no annual max and an annual out-of-pocket maximum. Average allowed amounts by procedure were used to establish a total claim costs by benefit category for In-Network claims. Coinsurance levels where then determined by benefit category, defined as Class I through Class V in the preceding paragraph, and the ratio of the resulting claim costs with coinsurance to the total claim costs with 100% coverage is then verified to be within the AV of 70% plus or minus 2% or 85% plus or minus 2%.

Actuarial Value Calculation

The Actuarial Value (AV) calculation is determined as the ratio of the EHB claim costs of a certain benefit set in comparison to the claim costs of 100% coverage of the same benefits for In Network providers. The starting claim costs are adjusted for necessary coinsurance adjustments by pediatric benefit class using Table 1A. The table below shows the AV calculation for the Anthem Dental Pediatric Plans.

Benefit Class	Starting Claim Cost	Anthem Dental Pediatric	Anthem Dental Pediatric Enhanced	100% Coverage w/no deductible
Class I	$13.10	$13.10	$14.85	$15.31
Class II	$3.85	$3.85	$5.45	$8.34
Class III	$0.17	$0.17	$0.17	$0.39
Class IV	$0.36	$0.36	$0.36	$0.54
Total Claim Cost	$17.48	$17.48	$20.83	$24.57
Actuarial Value		**71.2%**	**84.8%**	

Mortality

Not Applicable

Persistency

Not Applicable

Premium Modalization Rules

Not Applicable

Claim Liability and Reserves

Incurred but not paid (IBNP) reserves which includes an amount for claim amounts reported but not yet paid will be established using a lag factor approach. This method uses claim payment histories to estimate the amount of claims that have been incurred in a particular time period. From the incurred amount, the actual paid amount is subtracted to get the IBNP reserve.

Active Life Reserves

Not Applicable, there are no active life reserves for this product.

Coinsurance Adjustment

Coinsurance amounts may be equal for benefits provided by participating providers, or they may differ depending on whether the member gets services from a participating or a non-participating provider. Additionally, coinsurance amounts may differ between Pediatric and Adult plans. To determine the coinsurance adjustment factors that apply to a given product option, refer to TABLE-1.

Deductible Adjustment

Deductibles, if present, are $50 per person per benefit year. Deductible factors are applied to Adult plan claim costs. The benefit year deductible can either apply to diagnostic and preventive services, or it can be waived for diagnostic and preventive services. Factors for the two deductible options are found in TABLE-2. Pediatric plans are subject to a $50 deductible on non-Class I services.

Annual Maximum Adjustment

The annual maximum for each person can be between $500 and $2,000 per benefit year. Adjustment factors are shown in TABLE-3. Pediatric benefits do not have an annual maximum amount on participating provider benefits and a $1,000 annual max on non-participating provider benefits which is reflective in the Pediatric starting claim costs.

Dependent Age Adjustment

Dependents are children of the individual. All product options assume that children of enrolled individuals are covered up to age 26, regardless if they are a student or not.

If the dependent child is under the age of 19, they will have a Pediatric EHB dental benefit plan design. If the dependent child is between the ages of 19 up to age 26, they will receive an Adult dental benefit plan design. Dependent coverage up to age 26 is assumed in the starting claims cost, so no claim factors are needed for this pricing assumption.

Geographic Area Adjustment

Anthem BCBS only markets to individuals who reside in the state of Colorado. This rating model does not use different geographic areas within Colorado, therefore the rates developed in this model are used for the entire state of Colorado. Given that rates apply to the entire state, one geographic area adjustment factor is used for all rates.

The Geographic Area Adjustment varies by rating area and is in TABLE-4.

Occupational Adjustment

An occupational adjustment factor is not used in this rating model.

Prior Coverage

These Anthem Dental products may have waiting periods for Class II and Class III services for Adult plans, as discussed below. In some circumstances, if the individual purchaser has had prior comparable coverage, waiting periods will be waived. However, prior coverage is not a pricing variable used in the pricing model. There is no waiting period for Pediatric EHB benefits.

Benefit waiting period factor

Certain Adult plans may have waiting periods before certain categories of services will be covered under the plan. These waiting periods can apply to basic services, major services. If applicable, the waiting period for basic services will be 6 months, and the waiting period for major services will be 12 months. For purposes of waiting periods, Endodontic, Periodontic, and Oral Surgery services are included in major services and have a 12 month waiting period. The Pediatric EHB benefit does not have any waiting periods on services other than dentally necessary orthodontia, which has a 12 month waiting period which is figured into the

orthodontia starting claim cost. The appropriate adjustment for claims cost can be found in TABLE-5.

Reimbursement

The assumed level of provider reimbursement in the starting claims cost is set at the average of national dental submitted charges. The allowed reimbursement for the Anthem Dental Pediatric/Adult/Family products are the same whether or not the member sees a participating provider or a non-participating provider. The reimbursement adjustment factors for the Anthem Dental Pediatric/Adult/Family products are found in TABLE-6.

Orthodontia

Dentally necessary orthodontia is part of the Pediatric EHB benefit. When a non-participating provider is used, there is a $1,000 Lifetime Maximum benefit. There is no Lifetime Maximum benefit when a participating provider is used. Supplemental cosmetic child orthodontia is included for family purchasers that select the Anthem Dental Family Enhanced Plan for child dependents age 8 up to age 19.

Retention

Retention is a percentage of gross premiums and includes administrative expense, profit and Contingency, and premium tax as required. The retention table is shown in TABLE-9. The retention also includes provision for a writing agent commission as well as a commission override if applicable. The retention breakout differs between products sold On-Exchange, however the total retention is equivalent to achieve the same price as shown in TABLE-9.

Expected Loss Ratio

The expected loss ratio for this product is 70.54%. This equals 100% less the retention percentage.

Premium

The Anthem Dental Rating Worksheet (Exhibit 1) yields per member per month rates. The maximum number of child dependents that premiums would be collected for is three as determined by Exhibit 3. The premium for the Anthem Dental Family product is the sum of the individual premiums of the Pediatric and Adult benefits multiplied by the Family Factor.

Provider Usage Factor

The Anthem Dental Pediatric/Adult/Family products use the Anthem Prime network. Provider usage factors for the Anthem Dental Pediatric/Adult/Family products are shown in TABLE-7. The factor which applies to participating providers, and the inverse, which applies to non-participating providers, will be applied respectively to determine the Participating Provider premium and the Non-Participating premium in the Rating Worksheet. The final premium rate is then the sum of the premiums for the participating provider benefits and the non-participating provider benefits.

To the best of my knowledge, this rate filing is in compliance with applicable laws and regulations of the state of Colorado, and with the rules of the Department of Insurance. I certify that the rates are not excessive, inadequate or unfairly discriminatory. I also certify that the rates are reasonable in relation to the benefits provided. The actuarial methods, considerations and analysis used in forming my opinion conform to the relevant Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

Robert L Mikkel

7/19/13

Robert L. Mikkelsen, F.S.A., M.A.A.A.
Actuary

Date

Rocky Mountain Hospital and Medical Services, Inc.
Actuarial Memorandum
Anthem Dental Rate Manual

A. Summary

Reason(s) for the rate filing
This is a new rate filing.

Requested Rate Action
No rate action requested as this is a new rate filing and there is no historical data.

Marketing method(s)
This product will be marketed and sold On Exchange and Off Exchange by licensed brokers, via the internet and direct response to groups and individuals and their families residing in Colorado. It will be administered by DeCare Dental which is a licensed dental administrator.

Premium classification
Premiums for this product will vary by the following criteria: Benefits covered (coinsurance amounts, annual maximum benefits on adult benefits, deductibles, etc), age of the member which dictates the type of benefits available.

Product descriptions
This dental contract provides a variety of dental benefits that can be provided by an Anthem contracted provider, or a non-contracted provider. A detailed description of the benefit options may be found in the contract filing. In addition, a brief summary of the dental benefits is provided on page 2 of the rate manual portion of this rate filing.

Policy/Rider form
The memorandum address the following policy/rider forms

- Small Group policies:
  - 13-03271.06-SG-EX
  - 13-03271.06-SG
- Individual policies:
  - 13-03281.06-IND-EX
  - 13-03281.06-IND

Age basis
Members with an issue age below 19 will receive pediatric premiums associated with those benefits. Members with an issue age 19 and older will receive adult premiums associated with those benefits. All renewals will use the renewal age to set premiums.

Renewability provision
This product is guaranteed renewable.

B. Assumption, Acquisition or Merger

The product in this rate filing was not part of an assumption, acquisition, or merger with another company.

C. Rating Period

The rating period for this product and rate filing covers a one year period. The effective date, or the starting date, will be January 1, 2014, and the end date will be one year after the effective date. In addition, the effective date will not be before the approval date of this rate filing by the Colorado Department of Insurance.

D. Underwriting

The insured's application denotes the selected product, and effective date of coverage. An insured that cancels the Anthem dental plan cannot re-enroll for two years.

E. Effect of Law Changes

Not Applicable

F. Rate History

This is a new product and a new rate filing, therefore there is no prior rate history.

G. Coordination of Benefits

All coordination of benefit savings has been reflected in the baseline starting claims cost.

H. Relation of Benefits to Premium

The premiums are determined by developing the claims costs based on benefit design and group or individual's demographics and then dividing that number by the 1 minus the retention. TABLE-9 (given below) details each specific component of the retention load. These expenses are based on anticipated needs of Colorado-specific business. The anticipated retention is 29.46% and therefore the loss ratio is 70.54% which is well above the minimum of 60% set forth in CO regulation 4-24-11, section 6.H.3.b.

Retention Components	**On-Exchange**	**Off-Exchange**	**Explanation**
Administration Expense	12.00%	12.00%	*See Exhibit 7
Premium Tax	1.00%	1.00%	CO Statute
ACA Insurer Fee	2.46%	2.46%	Federal Fee
Exchange Fee	0.00%	0.00%	0 cost
Commission	8.00%	8.00%	*See Exhibit 7
Profit / Contingency	6.00%	6.00%	*See Section J
Retention	**29.46%**	**29.46%**	

I. Lifetime Loss Ratio

The products included in this rate filing were not priced using a lifetime loss ratio standard.

J. Provision for Profit and Contingencies

The Provision for Profit and Contingencies is set at 6% - below the 7% maximum outlined in CO regulation 4-24-11, section 6.J. This 6% is factored into retention to allow for accumulation of fund surplus and reserves necessary for Anthem BCBS to have adequate funds on hand to provide for unexpected claim volatility and fluctuations.

K. Complete Explanation as to How the Proposed Rates were Determined

Please refer to the the Dental Rate Manual that is attached to this memorandum

L. Trend

The starting claim costs were developed for an effective mid-point date of July 1st, 2012. The trend formula is (1 + (trend %/100))^ ((mid-point of rating period – July 1, 2012 expressed in integer half months)/24). Starting July 1st, 2012, claim costs are expected to increase at a trend of 5.00% annually in half-month increments. Premium rates will be guaranteed for 12 months, but for purposes of new sales, will change annually using the middle of the rating period to calculate the trend amount. For example, the January 1st, 2014 to December 31st, 2014 uses a rating period midpoint of June 30th, 2014 in calculating the trend amount.

The 5% projected trend assumption is composed of the following 3 components

- Utilization: 1.5% increase in services per exposure because of the expectation that the influx of previously uninsured will utilize more than the average person in year 1
- Unit cost: 2.0% increase in allowed charges from dental providers because the dental CPI is forecasted to increase more than 3% due to economic improvements and pent up demand to increase prices – this will mostly impact the non-participating provider
- Service Mix: 1.5% increase due to influx of the uninsured that will need more intense (Basic) services than the average policyholders.

Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. The membership steadily grew until 2013 and is starting to level off. As a result of the changing membership, the claim trends do not increase as one would expect because the new membership are selecting plans that have benefits that are less rich. As noted above, we do expect that the membership for Anthem Dental Adult / Pediatric will likely have a lot of pent up demand.

Table L.1

Statistics by Incurred Year

Year	Period	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Net Trend
2010	Starts Apr	4,692	9,009	$241,048	$241,048	$0	1,330	n/a
2011	CY	20,830	40,269	$896,589	$896,589	$0	5,268	-16.8%
2012	CY	38,783	74,929	$1,560,407	$1,556,209	$4,198	9,535	-6.5%
2013	YTD June	22,268	42,983	$863,043	$794,465	$68,577	4,949	-3.6%
All	Total	**86,573**	**167,190**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	

Table L.2

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Month

Year	Month	Subscriber Months	Member Months	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts
2010	1	0	0	$0	$0	$0	0
2010	2	0	0	$0	$0	$0	0
2010	3	0	0	$0	$0	$0	0
2010	4	64	148	$4,117	$4,117	$0	22
2010	5	242	448	$11,792	$11,792	$0	60
2010	6	298	556	$12,270	$12,270	$0	76
2010	7	399	743	$19,910	$19,910	$0	116
2010	8	474	905	$22,930	$22,930	$0	134
2010	9	592	1,147	$27,856	$27,856	$0	167
2010	10	730	1,437	$37,886	$37,886	$0	202
2010	11	849	1,655	$43,918	$43,918	$0	234
2010	12	1,044	1,970	$60,369	$60,369	$0	319
2011	1	1,314	2,560	$49,817	$49,817	$0	293
2011	2	1,431	2,799	$57,388	$57,388	$0	357
2011	3	1,517	2,965	$75,785	$75,785	$0	440
2011	4	1,566	3,035	$65,564	$65,564	$0	382
2011	5	1,639	3,158	$76,557	$76,557	$0	442
2011	6	1,654	3,202	$78,525	$78,525	$0	468
2011	7	1,729	3,375	$81,911	$81,911	$0	450
2011	8	1,820	3,532	$93,680	$93,680	$0	557
2011	9	1,882	3,622	$63,690	$63,690	$0	386
2011	10	1,972	3,768	$71,239	$71,239	$0	431
2011	11	2,063	3,962	$80,260	$80,260	$0	480
2011	12	2,243	4,291	$102,173	$102,173	$0	582
2012	1	2,699	5,185	$122,698	$122,666	$32	688
2012	2	2,810	5,419	$112,787	$112,751	$36	701
2012	3	2,892	5,608	$116,880	$116,834	$46	731
2012	4	2,961	5,743	$115,993	$115,924	$70	711
2012	5	3,016	5,832	$113,131	$113,040	$91	746
2012	6	3,092	5,978	$123,423	$123,278	$145	777
2012	7	3,275	6,351	$127,931	$127,724	$207	769
2012	8	3,386	6,557	$148,147	$147,819	$328	908
2012	9	3,437	6,637	$129,136	$128,724	$412	823
2012	10	3,614	6,952	$146,397	$145,760	$637	915
2012	11	3,717	7,154	$152,312	$151,388	$924	899
2012	12	3,884	7,513	$151,572	$150,302	$1,270	867
2013	1	3,869	7,461	$171,506	$169,501	$2,005	979
2013	2	3,849	7,392	$143,835	$141,496	$2,338	828
2013	3	3,785	7,266	$142,227	$138,727	$3,499	897
2013	4	3,786	7,294	$145,004	$138,480	$6,523	871
2013	5	3,583	6,982	$133,282	$122,013	$11,269	782
2013	6	3,396	6,588	$127,189	$84,248	$42,941	592

M. Credibility

This product is new and thus does not have any experience. So, we used a similar product's information displayed in section N. This data is fully credible since there are more than 2,000 life years (24,000 members months) and 2,000 claims –totals are in Table N.1 in Section N.

N. Data Requirements

This is a new product and thus there are no earned premiums, incurred claims, actual benefits ratios, number of claims, average covered lives and number of policyholders to submit on a Colorado-only basis for at least 3 years. Since this is a new product, we selected the "Prime / Complete Lite" as a proxy for our data. The enrollment started in April 2010 and has continued through June 2013. Below is the yearly summary.

Table N.1

Colorado "Prime / Complete Lite" Experience Period 2010-01-01 to 2013-06-30

Statistics by Incurred Year

													Average	
Year	Period	Subscriber Months	Member Months	Billed Premium	Total Incurred Claims	Paid on Incurred Claims	IBNR	Claim Counts	Loss Ratio	Premium PMPM	Incurred PMPM	Net Trend	Subscribers	Members
2010	Starts Apr	4,692	9,009	$294,677	$241,048	$241,048	$0	1,330	82%	$32.71	$26.76	n/a	616	1,183
2011	CY	20,830	40,269	$1,288,819	$896,589	$896,589	$0	5,268	70%	$32.01	$22.26	-16.8%	1,872	3,608
2012	CY	38,783	74,929	$2,428,330	$1,560,407	$1,556,209	$4,198	9,535	64%	$32.41	$20.83	-6.5%	3,424	6,614
2013	YTD June	22,268	42,983	$1,389,503	$863,043	$794,465	$68,577	4,949	62%	$32.33	$20.08	-3.6%	3,636	7,031
All	Total	**86,573**	**167,190**	**$5,401,329**	**$3,561,085**	**$3,488,310**	**$72,775**	**21,082**	**66%**	**$32.31**	**$21.30**			

O. Side-by-Side Comparison

This is a new product and thus there is nothing that can be compared.

P. Benefits Ratio Projections

The following is the 2014 projection of incurred claims, revenue and benefit loss ratios. Note that this is a new filing and there is no rate change request –that's why there are zeroes in the "Without Change" section.

Table P.1

	With Change			Without Change		
Date	**Prem**	**Clms**	**LR**	**Prem**	**Clms**	**LR**
1/1/2014	$459,985	$335,581	73%	$0	$0	n/a
2/1/2014	$633,483	$396,456	63%	$0	$0	n/a
3/1/2014	$797,830	$526,635	66%	$0	$0	n/a
4/1/2014	$825,590	$557,156	67%	$0	$0	n/a
5/1/2014	$822,762	$525,419	64%	$0	$0	n/a
6/1/2014	$820,104	$540,782	66%	$0	$0	n/a
7/1/2014	$821,525	$543,676	66%	$0	$0	n/a
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Q. Other Factors

Please refer to the information below and the Dental Rate Manual that is attached to this memorandum.

The purpose of this filing is to demonstrate compliance with minimum requirements of the state of Colorado and show that the benefits are reasonable in relation to premiums charged.

This Anthem Blue Cross and Blue Shield (Anthem BCBS) Anthem Dental Rate Manual applies to the Anthem Dental Pediatric/Adult/Family products which are HCR compliant. This rate manual applies to rates that are being used and developed on behalf of Rocky Mountain Hospital and Medical Services, Inc, also doing business as Anthem BCBS. This rate manual applies to Small Group policies 13-03271.06-SG-EX & 13-03271.06-SG, Individual policies 13-03281.06-IND-EX, and 13-03281.06-IND. Individuals will be able to select plans with a range of benefit design options. This rate manual and the rates developed by it will be effective January 1st, 2014.

The rating method begins with starting claim costs. Factors are then applied to these costs that develop rates based on the member's benefit plan. The methodology will use linear interpolation to derive the appropriate factors for benefits not explicitly stated in this rate manual. The rating steps are shown in the two rating worksheets in the back of the Anthem BCBS Anthem Dental Rate Manual. Exhibit 1 shows the rating worksheet template, and Exhibit 2 shows a sample rate calculation.

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Class II – Basic services; simple restorations, periodontics, endodontics and oral surgery
Class III – Major restorative services; prosthodontics and prosthetics
Class IV – Orthodontics; Dentally Necessary Orthodontics

Pediatric – Pediatric EHB Mandated Dental Benefits for individuals up to the age of 19
Adult – Dental Benefits for individuals age 19 and over
Family – Pediatric and Adult benefits purchased as a single contract. Individuals up to the age of 19 receive Pediatric benefits and individuals age 19 and over receive Adult benefits.
AV – Actuarial Value measured using benefits when using a participating provider represents the percentage of costs covered by the plan

Plan Offerings

Anthem Dental Pediatric Plan – Pediatric dental benefit with 70% AV
Anthem Dental Pediatric Enhanced Plan – Pediatric dental benefit with 85% AV
Anthem Dental Adult Plan – Adult dental benefit
Anthem Dental Adult Enhanced Plan – Adult dental benefit with higher coinsurance levels
Anthem Dental Family Plan – A combination of Anthem Dental Pediatric Plan and Anthem Dental Adult Plan with benefits based on the age of family members
Anthem Dental Family Enhanced Plan – A combination of Anthem Dental Pediatric Enhanced Plan and Anthem Dental Adult Enhanced Plan with benefits based on the age of family members; includes cosmetic orthodontia for children from age 8 up to age 19

Morbidity

The starting claim cost for each class of service (Diagnostic & Preventive, Basic, Major, and Orthodontics) is based on analyses of several recent years of claim data. An extensive claim database was used to derive this experience. This data is supplemented as needed by data provided by Milliman USA, an Actuarial Consulting firm.

Analyses were conducted separately for each of the following services: diagnostic and preventive, basic restorative, periodontic, endodontic, oral surgery, major restorative, prosthodontics, prosthetic repairs and orthodontics. The results were then aggregated into Class I, Class II, Class III and Class IV services.

The starting claim costs are developed assuming reimbursement at the full amount of the dentist submitted charge, where the dentist submitted charge is equal to a national average. The starting claim costs experience has a midpoint date of July 1, 2012.

The monthly starting Pediatric and Adult benefit claim costs are:

	Pediatric	Adult
Class I Diagnostic and Preventive Services	$13.10	$19.29
Class II Basic Services	$ 3.85	$11.79
Class III Major Services	$ 0.17	$ 8.25
Class IV Orthodontic Services	$ 0.39	$ 0.00

The Adult plans starting claim costs assume coinsurance levels of 100% for Class I services, 50% for Class II services, 50% for Class III services, a $50 per person deductible and a $1,200 annual maximum. The specific procedures defined by the PPACA Stand-Alone Dental Plan Procedures for Colorado dated May 31, 2013 are the only procedures covered in the Pediatric starting claim costs. The Pediatric starting claim costs assume coinsurance levels of 90% for Class I services, 50% for Class II services, 50% for Class III services, and also include Class IV Orthodontic Services as Dentally Necessary Orthodontia assuming a coinsurance level of 50%. All Pediatric plan starting claim costs assume no annual maximum and an out-of-pocket maximum of $700 per member up to a maximum of $1,400 per family. The pediatric plans also include a $50 deductible for non-Diagnostic & Preventive services which is included in the starting claim costs. TABLE-1 (see Rate Manual for Tables TABLE-1 through TABLE-10 referenced in this Actuarial Memorandum) lists the coinsurance percentages being offered and their corresponding adjustment factors for each of the three classes of services to reflect the differences from the coinsurance levels used to establish the starting claim costs. Due to the out-of-pocket maximum on the pediatric benefit, Class IV claim costs will not change with varying coinsurance.

Pediatric EHB Actuarial Value

The model used to develop the Actuarial Value (AV) for the pediatric EHB plans was comprised of dental claims data of members under the age of 19. The data was used to develop annual utilization by procedure code for all covered services under the pediatric EHB while including utilization adjustments for non-traditional benefits such as no annual max and an annual out-of-pocket maximum. Average allowed amounts by procedure were used to establish a total claim costs by benefit category for In-Network claims. Coinsurance levels where then determined by benefit category, defined as Class I through Class V in the preceding paragraph, and the ratio of the resulting claim costs with coinsurance to the total claim costs with 100% coverage is then verified to be within the AV of 70% plus or minus 2% or 85% plus or minus 2%.

Actuarial Value Calculation

The Actuarial Value (AV) calculation is determined as the ratio of the EHB claim costs of a certain benefit set in comparison to the claim costs of 100% coverage of the same benefits for In Network providers. The starting claim costs are adjusted for necessary coinsurance adjustments by pediatric benefit class using Table 1A. The table below shows the AV calculation for the Anthem Dental Pediatric Plans.

Benefit Class	Starting Claim Cost	Anthem Dental Pediatric	Anthem Dental Pediatric Enhanced	100% Coverage w/no deductible
Class I	$13.10	$13.10	$14.85	$15.31
Class II	$3.85	$3.85	$5.45	$8.34
Class III	$0.17	$0.17	$0.17	$0.39
Class IV	$0.36	$0.36	$0.36	$0.54
Total Claim Cost	$17.48	$17.48	$20.83	$24.57
Actuarial Value		**71.2%**	**84.8%**	

Mortality

Not Applicable

Persistency

Not Applicable

Premium Modalization Rules

Not Applicable

Claim Liability and Reserves

Incurred but not paid (IBNP) reserves which includes an amount for claim amounts reported but not yet paid will be established using a lag factor approach. This method uses claim payment histories to estimate the amount of claims that have been incurred in a particular time period. From the incurred amount, the actual paid amount is subtracted to get the IBNP reserve.

Active Life Reserves

Not Applicable, there are no active life reserves for this product.

Coinsurance Adjustment

Coinsurance amounts may be equal for benefits provided by participating providers, or they may differ depending on whether the member gets services from a participating or a non-participating provider. Additionally, coinsurance amounts may differ between Pediatric and Adult plans. To determine the coinsurance adjustment factors that apply to a given product option, refer to TABLE-1.

Deductible Adjustment

Deductibles, if present, are $50 per person per benefit year. Deductible factors are applied to Adult plan claim costs. The benefit year deductible can either apply to diagnostic and preventive services, or it can be waived for diagnostic and preventive services. Factors for the two deductible options are found in TABLE-2. Pediatric plans are subject to a $50 deductible on non-Class I services.

Annual Maximum Adjustment

The annual maximum for each person can be between $500 and $2,000 per benefit year. Adjustment factors are shown in TABLE-3. Pediatric benefits do not have an annual maximum amount on participating provider benefits and a $1,000 annual max on non-participating provider benefits which is reflective in the Pediatric starting claim costs.

Dependent Age Adjustment

Dependents are children of the individual. All product options assume that children of enrolled individuals are covered up to age 26, regardless if they are a student or not.

If the dependent child is under the age of 19, they will have a Pediatric EHB dental benefit plan design. If the dependent child is between the ages of 19 up to age 26, they will receive an Adult dental benefit plan design. Dependent coverage up to age 26 is assumed in the starting claims cost, so no claim factors are needed for this pricing assumption.

Geographic Area Adjustment

Anthem BCBS only markets to individuals who reside in the state of Colorado. This rating model does not use different geographic areas within Colorado, therefore the rates developed in this model are used for the entire state of Colorado. Given that rates apply to the entire state, one geographic area adjustment factor is used for all rates.

The Geographic Area Adjustment varies by rating area and is in TABLE-4.

Occupational Adjustment

An occupational adjustment factor is not used in this rating model.

Prior Coverage

These Anthem Dental products may have waiting periods for Class II and Class III services for Adult plans, as discussed below. In some circumstances, if the individual purchaser has had prior comparable coverage, waiting periods will be waived. However, prior coverage is not a pricing variable used in the pricing model. There is no waiting period for Pediatric EHB benefits.

Benefit waiting period factor

Certain Adult plans may have waiting periods before certain categories of services will be covered under the plan. These waiting periods can apply to basic services, major services. If applicable, the waiting period for basic services will be 6 months, and the waiting period for major services will be 12 months. For purposes of waiting periods, Endodontic, Periodontic, and Oral Surgery services are included in major services and have a 12 month waiting period. The Pediatric EHB benefit does not have any waiting periods on services other than dentally necessary orthodontia, which has a 12 month waiting period which is figured into the

orthodontia starting claim cost. The appropriate adjustment for claims cost can be found in TABLE-5.

Reimbursement

The assumed level of provider reimbursement in the starting claims cost is set at the average of national dental submitted charges. The allowed reimbursement for the Anthem Dental Pediatric/Adult/Family products are the same whether or not the member sees a participating provider or a non-participating provider. The reimbursement adjustment factors for the Anthem Dental Pediatric/Adult/Family products are found in TABLE-6.

Orthodontia

Dentally necessary orthodontia is part of the Pediatric EHB benefit. When a non-participating provider is used, there is a $1,000 Lifetime Maximum benefit. There is no Lifetime Maximum benefit when a participating provider is used. Supplemental cosmetic child orthodontia is included for family purchasers that select the Anthem Dental Family Enhanced Plan for child dependents age 8 up to age 19.

Retention

Retention is a percentage of gross premiums and includes administrative expense, profit and Contingency, and premium tax as required. The retention table is shown in TABLE-9. The retention also includes provision for a writing agent commission as well as a commission override if applicable. The retention breakout differs between products sold On-Exchange and Off-Exchange, however the total retention is equivalent to achieve the same price as shown in TABLE-9.

Expected Loss Ratio

The expected loss ratio for this product is 70.54%. This equals 100% less the retention percentage.

Premium

The Anthem Dental Rating Worksheet (Exhibit 1) yields per member per month rates. The maximum number of child dependents that premiums would be collected for is three as determined by Exhibit 3. The premium for the Anthem Dental Family product is the sum of the individual premiums of the Pediatric and Adult benefits multiplied by the Family Factor.

Provider Usage Factor

The Anthem Dental Pediatric/Adult/Family products use the Anthem Prime network. Provider usage factors for the Anthem Dental Pediatric/Adult/Family products are shown in TABLE-7. The factor which applies to participating providers, and the inverse, which applies to non-participating providers, will be applied respectively to determine the Participating Provider premium and the Non-Participating premium in the Rating Worksheet. The final premium rate is then the sum of the premiums for the participating provider benefits and the non-participating provider benefits.

To the best of my knowledge, this rate filing is in compliance with applicable laws and regulations of the state of Colorado, and with the rules of the Department of Insurance. I certify that the rates are not excessive, inadequate or unfairly discriminatory. I also certify that the rates are reasonable in relation to the benefits provided. The actuarial methods, considerations and analysis used in forming my opinion conform to the relevant Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

Robert Mikkel

7/12/13

Robert L. Mikkelsen, F.S.A., M.A.A.A.
Actuary

Date

Anthem Blue Cross Blue Shield

ANTHEM DENTAL RATE MANUAL

Anthem Dental Pediatric/Adult/Family Products

Table of Contents

Schedule of Benefits
The following schedules of benefits will be made available to individuals depending on the member's age. Note that the schedule of benefits, for the non-participating provider benefit schedule could be different than the participating provider benefit schedule. Also, the schedule of benefits could be different for Adult members and Pediatric members.

Anthem Dental Pediatric/Adult/Family

Adult Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative*	NC or 10% to 90%
Endodontics*	NC or 10% to 90%
Periodontics*	NC or 10% to 90%
Oral Surgery*	NC or 10% to 90%
Major Restorative*	NC or 10% to 60%
Prosthetic Repairs/Adjustments*	NC or 10% to 60%
Prosthetics*	NC or 10% to 60%
Orthodontics*	NC

* NC denotes no coverage

Individual Deductible	$50 per person
Family Deductible	$50 per person
Annual Maximum	$500 - $2,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Deductible levels available at $50 at the individual level.
Annual maximum available within the range in increments of $250.
Annual Out-Of-Pocket (OOP) Maximum is not available.

Pediatric Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative	50% to 90%
Endodontics	50% to 90%
Periodontics	50% to 90%
Oral Surgery	50% to 90%
Major Restorative	50% to 60%
Prosthetic Repairs/Adjustments	50% to 60%
Prosthetics	50% to 60%
Dentally Necessary Orthodontics	50% to 60%
Cosmetic Orthodontics*	NC or 50% to 60%

* NC denotes no coverage

Individual Deductible	$50
Family Deductible	$50 per person
Annual Maximum	N/A for Participating Providers; $1,000 for Non-Participating Providers
Annual Out of Pocket Maximum Individual/Family	$700/$1,400
Dentally Necessary Orthodontics Maximum	No Maximum for Participating Providers; $1,000 LT Max for Non-Participating Providers
Cosmetic Orthodontia Lifetime Maximum	$1,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Annual Out-Of-Pocket (OOP) Maximum on Pediatric EHB plans of $700 per member up to a maximum of $1,400 per family.

Plan Options Available

- Cosmetic Orthodontia is included with the Anthem Dental Family Enhanced Plan for children age 8 up to age 19
- Annual OOP Maximum may be $1,000 per member up to a maximum of $2,000 per family

Individual Dental Rate Manual Instructions

All calculations can be completed in the following Anthem Dental Rating Worksheet (see Exhibit 1). Linear interpolation is to be followed to derive the appropriate factors for benefits not explicitly given in this rate manual.

Step 1: Fill in the benefit plan information: the Individual's name, the product selected, location, and the effective date of the contract. Note that the benefits may vary between the participating provider columns and the non-participating columns as well as between Adult and Pediatric columns. Note that 100/80/50 denotes coverage at 100% for Diagnostic and Preventive (Class I), 80% coverage for Basic Restorative (Class II), and 50% coverage for Major Restorative (Class III).

Step 2: Coinsurance Adjustment Coinsurance adjustment factors (see TABLE-1) are given for different combinations of services. Based on the plan's benefits, find the appropriate set of coinsurance adjustment factors in TABLE-1A & TABLE-1B for Pediatric and Adult benefits respectively, and enter them in the appropriate coinsurance adjustment worksheet (Exhibits 4A & 4B) and enter the results of coinsurance adjustment worksheet into the coinsurance adjustment row of the rating worksheet.

Step 3: Multiply the Adult and Pediatric starting claim cost by the appropriate coinsurance adjustment factor for each class of service. Enter the results on the line in Exhibit 1 labeled "Adjusted starting claim cost". On the line labeled "Combined claim cost" enter the sum of the Class I, Class II, and Class III adjusted starting claim costs.

Step 4: Enter the Deductible adjustment from TABLE-2. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to a deductible and that is reflected in the Pediatric starting claim costs.

Step 5: Based on the plans annual maximum benefit, enter the appropriate annual maximum adjustment factor from TABLE-3. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to an annual max and that is reflected in the Pediatric starting claim costs.

Step 6: Geographic Area Adjustment: Refer to TABLE-4, and pick the appropriate factor based on the three-digit zip code the member resides in. Enter the factor on the rating sheet.

Step 7: Annual Trend The starting claim costs were developed with a baseline date of July 1, 2012. Claim costs are expected to increase at a trend of 5.00% annually in half month increments. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$. Enter the compounded trend amount on the annual trend line on the rating worksheet. For example if the quote applies to period of January 1st, 2014 to December 31st, 2014, the trend period is from July 1st, 2012 to June 30th, 2014 (the mid-point of the rating period), or 48 half months.

Step 8: For benefit plan designs that include waiting periods for certain benefit categories, the appropriate factor in TABLE-5 will be entered in the columns on the line labeled "Benefit Waiting Period factor". For Pediatric plans, the factor is 1.00 because the Pediatric benefits are not subject to waiting periods and that is reflected in the Pediatric starting claim costs.

Step 9: Reimbursement Factor: Refer to TABLE-6, and pick the appropriate factor based on the member's three-digit zip code and enter it on the rating sheet. The same factor will be used in the in the participating provider columns and the non-participating provider columns for both Pediatric and Adult plans.

Step 10: Provider Usage Factor: Refer to TABLE-7, and enter the provider usage factors in the appropriate columns.

Step 11: Out-of-Pocket Maximum Factor: The Pediatric dental benefit has an annual Out-of-Pocket Maximum of $700 for an individual up to a limit of $1,400 for the family priced into the Pediatric dental product and has a factor of 1.00 in the rating worksheet. If a $1,000 Out-of-Pocket Maximum for an individual up to a limit of $2,000 for the family members up to the age of 19 is used, a factor of .975 is used for the Out-of-Pocket Maximum factor line in the Pediatric columns in the rating worksheet.

Step 12: Family Factor: Enter the appropriate Family Factor from TABLE-8 depending on the product that is purchased. For purchasers of an Anthem Dental Family product, the Family Factor is to account for administrative efficiencies and decreased anti-selection risk of a family purchasing instead of individual purchasers of separate Pediatric and Adult policies.

Step 13: On the line labeled "Total Claim Cost", enter the product of multiplying the combined claim cost from step 3 by the factors in steps 4 through 12.

Step 14: Retention: Enter 1 minus the retention amount from TABLE-9. The expected loss ratio for this product is 70.54% for On-Exchange and Off-Exchange.

Step 15: On the line labeled "Gross Monthly Premium": enter the result of dividing the amount from step 13 by the amount in step 14.

Step 16: Blended Premium: To determine the blended premium rate, add the results from step 14, for the Participating Provider column, and the Non-Participating Provider column. Do this for both the Pediatric and Adult columns.

Step 17: Ortho Premium: The orthodontia premium is calculated in Exhibit 5. Dentally Necessary Orthodontia is included in all Pediatric plans and is the Pediatric class IV claim cost. This amount should be entered into the line 1 of Exhibit 5 under the Pediatric column. For the Anthem Dental Family Enhanced product, cosmetic orthodontia is included for members age 8 up to age 19 and the claim cost of the cosmetic orthodontia is located in TABLE-10 and entered in line 2 of Exhibit 5 in both the Pediatric and Adult columns. The sum of the costs for the Pediatric and Adult costs are entered in line 3 of Exhibit 5. In line 4 of Exhibit 4, enter 1 minus the retention percentage from TABLE-9. In Exhibit 5, line 5 equals

line 3 divided by line 4 to give the orthodontia premium amount to enter for the Orthodontia Premium in the rating worksheet.

Step 18: Final Premium Rates: Enter the sum of the Blended Premium Rate and Ortho Premium from step 16 and step 17 and enter into the Final Premium Rate for both the Pediatric and Adult columns.

Step 19: For the Anthem Dental Pediatric and Anthem Dental Adult products, the rates from step 18 are the rates to use multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. For the Anthem Dental Family products, Exhibit 3 is used to calculate the number of pediatric and adult premiums that will be rated for based on the makeup of the family, and the resulting values from Exhibit 3 are used in the Rating Worksheet for the Number of Pediatric Premiums and the Number of Adult Premiums, respectively. The Total Contract Premium is calculated by multiplying the rates in the Pediatric column from step 18 by the Number of Pediatric Premiums and adding the product of the Final Premium Rate in the Adult column from step 18 and the Number of Adult Premiums.

TABLE - 1A
Pediatric Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.1111	1.020	100%	2.000	1.050	100%	2.000	1.100
90%	1.0000	1.000	80%	1.600	1.041	50%	1.000	1.000
80%	0.8889	0.990	60%	1.200	1.010			
70%	0.7778	0.980	50%	1.000	1.000			

Default plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4A for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 1B
Adult Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.0000	1.000	90%	1.800	1.046	60%	1.200	1.030
90%	0.9000	0.993	80%	1.600	1.026	50%	1.000	1.000
80%	0.8000	0.992	60%	1.200	1.005	30%	0.600	0.965
75%	0.7500	0.988	50%	1.000	1.000	25%	0.500	0.955
50%	0.5000	0.970	30%	0.600	0.974	15%	0.300	0.945
			25%	0.500	0.964	0%	0.000	0.000
			15%	0.300	0.944			
			0%	0.000	0.000			

Default plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4B for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 2

Benefit Year Deductible Factors

	Factor
Deductible does not apply to Diagnostic and Preventive Services	1.00
Deductible does apply to Diagnostic and Preventive Services	0.95

Note:
A $50 per person deductible will apply to any Adult benefit set. The only variable regarding the deductible is whether or not the deductible applies to Diagnostic and Preventive Services. A $50 deductible applies to non-D&P services for Pediatric plans.

TABLE - 3

Annual Maximum Benefit Factors

Annual Maximum Amount	Factor
$500	0.9100
$750	0.9400
$1,000	0.9690
$1,200	1.0000
$1,250	1.0078
$1,500	1.0600
$1,750	1.0950
$2,000	1.1300
$2,500	1.2200

Note: For a quote that has D & P coverage only, annual maximum factors for all amounts equals amounts equals 1.00. Pediatric plans do not have an annual max therefore have a factor of 1.00 because the unlimted maximum is built into the starting claim cost.

TABLE - 4

Geographic Area Adjustment

Rating Area	Factor
Statewide	1.020

TABLE - 5

Benefit Waiting Period Factors

Services Covered	Factor
6 month waiting period on Basic Restorative and 12 month on non-D&P	0.975
12 month waiting period on Class III Only	1.000
Class I, Class II, and Class III are all covered with no waiting period	1.050

Note: Pediatric plans do not have waiting periods on non-orthodontia services therefore get a factor of 1.00.

TABLE - 6

Reimbursement Factors

Rating Area - Three-Digit Zips Included	Factor
Statewide	
Prime Network Reimbursement Factor	0.700
Non-Participating Reimbursement Factor	0.700

TABLE-7

Provider Usage Factors

Rating Area - Three-Digit Zips Included	**Factor**
Statewide	
Prime Network Usage Factor	0.507
Non-Participating Usage Factor	0.493

TABLE - 8

Family Factor

Product	**Factor**
Anthem Dental Pediatric Products	1.0000
Anthem Dental Adult Products	1.0000
Anthem Dental Family Products	0.9750

TABLE - 9

Retention Factor

	Retention as % of Premium	
	On-Exchange	Off-Exchange
Administration Expense	12.00%	12.00%
Premium Tax	1.00%	1.00%
ACA Insurer Fee	2.46%	2.46%
Exchange Fee	0.00%	0.00%
Commission	8.00%	8.00%
Profit / Risk Charge	6.00%	6.00%
Retention	**29.46%**	**29.46%**

TABLE - 10

Orthodontia Claim Costs

Orthodontia Benefit	**Claim Cost**
Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.36
Cosmetic Orthodontia per member per month cost $1,000 Lifetime Maximum with 12 Month Waiting Period Costemic Orthodontia is all orthodontia cases not deemed Dentally Necessary Orthodontia	$3.65
Dentally Necessary with no cost share for AV calculation Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.54

Exhibit 1 -- Individual Dental Rating Worksheet

Name	Product
Location (Zip Code)	Effective Date

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1												
Adjusted starting claim cost		Product of above 2 lines												
Combined Claim Cost		Sum of the 3 Classes												
Deductible adjustment		Refer to TABLE-2												
Annual maximum adjustment		Refer to TABLE-3												
Geographic area adjustment		Refer to TABLE-4												
Annual trend		Refer to Step 7												
Benefit waiting period factor		Refer to TABLE-5												
Reimbursement factor		Refer to TABLE-6												
Provider Usage factor		Refer to TABLE-10												
Out-Of-Pocket Max Factor		Refer to Step 11												
Family Factor		Refer to TABLE-8												
Total Claim Cost		Product of Combined Claims Cost factors and adjustments												
Retention	29.46%	Refer to TABLE-9	70.54%			70.54%			70.54%			70.54%		
Gross Monthly Premium		Total claim cost divided by (1 - Retention)	$0.00			$0.00			$0.00			$0.00		

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program		
Non-Participating Program		
Total	**$0.00**	**$0.00**

Ortho Premium	Refer to Exhibit 4 and Step 17	Pediatric	Adult
Total			

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total			

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total				**$0.00**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name	J. Doe
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6500	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.0200	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-10		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 4 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 3 -- Anthem Dental Family Product -- Number of Rates Worksheet

Name	J. Doe
Product	Anthem Dental Family Enhanced

Number of members in family	6
Number of non-child members (a)	2
Number of child members age 19 and older (b)	2
Number of child members under age 19 (c)	2

Number of non-child members to be rated (d):	2
Take the number (a)	
Number of children age 19 and older to be rated (e):	2
Take the lesser of (b) and 3	
Number of children age under age 19 to be rated (f)	1
Take the lesser of 3 minus (d) or (c)	

Number number of adult premiums rated	**4**
Take the sum of (d) and (e)	
Number of pediatric premiums to be rated for (f)	**1**

Exhibit 4A -- Pediatric Dental Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	90	50	50	50
3 Claim Impact Factors (Table-1)	1.111	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0200	1.0410	1.0000	1.0000
5 Total Change	1.1333	1.6656	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.6260	0.3740	1.0000
7 Total Weighted Change	1.1333	1.0427	0.3740	1.0000
8 Coinsurance Factor for Exhibit1	1.1333	1.4167		1.0000

Baseline plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 4B -- Adult Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	100	50	50	50
3 Claim Impact Factors (Table-1)	1.000	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0000	1.0260	1.0000	1.0000
5 Total Change	1.0000	1.6416	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.5283	0.4717	1.0000
7 Total Weighted Change	1.0000	0.8673	0.4717	1.0000
8 Coinsurance Factor for Exhibit1	1.0000	1.3390		1.0000

Baseline plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 5 -- Orthodontia Premium Worksheet		
Product		
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)		
Cosmetic Orthodontia (line 2)		
Total Orthodontia Claim Cost (line 3)		
Retention (line 4)		
Orthodontia Premium (line 5)		

Exhibit 6 -- Orthodontia Premium Worksheet -- Sample Calculation		
Product	Anthem Dental Family Enhanced	
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)	$0.39	$0.00
Cosmetic Orthodontia (line 2)	$3.65	$3.65
Total Orthodontia Claim Cost (line 3)	4.04	3.65
Retention (line 4)	70.54%	70.54%
Orthodontia Premium (line 5)	5.73	5.17

Exhibit 7

Development and Justification for Administrative Expense Load and Commission Load

Colorado Prime Network Products

These Prime Network dental products are administered by DeCare Dental which is a wholly owned subsidiary of WellPoint Inc. Anthem Blue Cross Blue Shield of Colorado is also a subsidiary of WellPoint Inc.

ADMINISTRATIVE EXPENSE

(a)	DeCare Dental administers a large block of small group dental risk products. Total incurred costs for administrative expenses for 2010 for the small group dental risk business administered by DeCare dental was:	$19,279,150
(b)	Total earned premium for 2010 for the small group dental risk business administered by DeCare Dental and mentioned in (a) above was:	$126,399,305
(c)	Incurred administrative costs as a percent of earned premium for 2010 for DeCare Dental's small group dental risk business was (a)/(b) which equals:	15.25%
(d)	Average annual premium per member per month (PMPM) for the small group dental business administered by DeCare Dental:	$24.43
(e)	Average monthly premium per member per month (PMPM) for the HCR compliant Prime Network business expected in Colorado:	$30.87
(f)	Ratio of average premium PMPM for DeCare small group business to expected average PMPM premium for Colorado Prime Network HCR business, equals (d) / (e):	0.791
(g)	Since the average expected Colorado dental premium is greater than the average DeCare small group dental premium, a lower percent of premium is needed to generate the needed administrative expense to operate the CO small group Prime % Complete business. That percentage is equal to (f) x (c) which equals:	12.07%

Anthem Blue Cross Blue Shield (BCBS) of Colorado does have a block of small group dental risk business. Below is some data regarding that business.

COMMISSION EXPENSE

(a)	Earned premium for 2012 for Anthem BCBS of Colorado small group dental business:	$5,229,195
(b)	Incurred commissions for 2012 for Anthem BCBS small group dental business:	$550,514
(c)	Ratio of commissions to premium for 2012 for Anthem BCBS small group dental	10.53%

(d) The 10.53% commission percentage above is a result of the commissions that were paid for Anthem BCBS's small group dental business in 2012. Generally most of the products have a 10% commission for the writing agent, and there are a few agreements in place in which a managing general agent receives a commission override. So, the commission in (c) above is made up of a 10% writing agent commission and a .43% commission override.
For the new Prime Network dental products, some of the sales will be made directly by the consumer without any compensation paid to a broker or a navigator, thereby having no commission expense. With this in mind, we are expecting an average commission rate for these HCR compliant products to be sold on and off exchange to be 8%.

Anthem Blue Cross Blue Shield

ANTHEM DENTAL RATE MANUAL

Anthem Dental Pediatric/Adult/Family Products

Table of Contents

Schedule of Benefits
The following schedules of benefits will be made available to individuals depending on the member's age. Note that the schedule of benefits, for the non-participating provider benefit schedule could be different than the participating provider benefit schedule. Also, the schedule of benefits could be different for Adult members and Pediatric members.

Anthem Dental Pediatric/Adult/Family

Adult Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative*	NC or 10% to 90%
Endodontics*	NC or 10% to 90%
Periodontics*	NC or 10% to 90%
Oral Surgery*	NC or 10% to 90%
Major Restorative*	NC or 10% to 60%
Prosthetic Repairs/Adjustments*	NC or 10% to 60%
Prosthetics*	NC or 10% to 60%
Orthodontics*	NC

* NC denotes no coverage

Individual Deductible	$50 per person
Family Deductible	$50 per person
Annual Maximum	$500 - $2,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Deductible levels available at $50 at the individual level.
Annual maximum available within the range in increments of $250.
Annual Out-Of-Pocket (OOP) Maximum is not available.

Pediatric Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative	50% to 90%
Endodontics	50% to 90%
Periodontics	50% to 90%
Oral Surgery	50% to 90%
Major Restorative	50% to 60%
Prosthetic Repairs/Adjustments	50% to 60%
Prosthetics	50% to 60%
Dentally Necessary Orthodontics	50% to 60%
Cosmetic Orthodontics*	NC or 50% to 60%

* NC denotes no coverage

Individual Deductible	$50
Family Deductible	$50 per person
Annual Maximum	N/A for Participating Providers; $1,000 for Non-Participating Providers
Annual Out of Pocket Maximum Individual/Family	$700/$1,400
Dentally Necessary Orthodontics Maximum	No Maximum for Participating Providers; $1,000 LT Max for Non-Participating Providers
Cosmetic Orthodontia Lifetime Maximum	$1,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Annual Out-Of-Pocket (OOP) Maximum on Pediatric EHB plans of $700 per member up to a maximum of $1,400 per family.

Plan Options Available

- Cosmetic Orthodontia is included with the Anthem Dental Family Enhanced Plan for children age 8 up to age 19
- Annual OOP Maximum may be $1,000 per member up to a maximum of $2,000 per family

Individual Dental Rate Manual Instructions

All calculations can be completed in the following Anthem Dental Rating Worksheet (see Exhibit 1). Linear interpolation is to be followed to derive the appropriate factors for benefits not explicitly given in this rate manual.

Step 1: Fill in the benefit plan information: the Individual's name, the product selected, location, and the effective date of the contract. Note that the benefits may vary between the participating provider columns and the non-participating columns as well as between Adult and Pediatric columns. Note that 100/80/50 denotes coverage at 100% for Diagnostic and Preventive (Class I), 80% coverage for Basic Restorative (Class II), and 50% coverage for Major Restorative (Class III).

Step 2: Coinsurance Adjustment Coinsurance adjustment factors (see TABLE-1) are given for different combinations of services. Based on the plan's benefits, find the appropriate set of coinsurance adjustment factors in TABLE-1A & TABLE-1B for Pediatric and Adult benefits respectively, and enter them in the appropriate coinsurance adjustment worksheet (Exhibits 4A & 4B) and enter the results of coinsurance adjustment worksheet into the coinsurance adjustment row of the rating worksheet.

Step 3: Multiply the Adult and Pediatric starting claim cost by the appropriate coinsurance adjustment factor for each class of service. Enter the results on the line in Exhibit 1 labeled "Adjusted starting claim cost". On the line labeled "Combined claim cost" enter the sum of the Class I, Class II, and Class III adjusted starting claim costs.

Step 4: Enter the Deductible adjustment from TABLE-2. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to a deductible and that is reflected in the Pediatric starting claim costs.

Step 5: Based on the plans annual maximum benefit, enter the appropriate annual maximum adjustment factor from TABLE-3. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to an annual max and that is reflected in the Pediatric starting claim costs.

Step 6: Geographic Area Adjustment: Refer to TABLE-4, and pick the appropriate factor based on the three-digit zip code the member resides in. Enter the factor on the rating sheet.

Step 7: Annual Trend The starting claim costs were developed with a baseline date of July 1, 2012. Claim costs are expected to increase at a trend of 5.00% annually in half month increments. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$. Enter the compounded trend amount on the annual trend line on the rating worksheet. For example if the quote applies to period of January 1st, 2014 to December 31st, 2014, the trend period is from July 1st, 2012 to June 30th, 2014 (the mid-point of the rating period), or 48 half months.

Step 8: For benefit plan designs that include waiting periods for certain benefit categories, the appropriate factor in TABLE-5 will be entered in the columns on the line labeled "Benefit Waiting Period factor". For Pediatric plans, the factor is 1.00 because the Pediatric benefits are not subject to waiting periods and that is reflected in the Pediatric starting claim costs.

Step 9: Reimbursement Factor: Refer to TABLE-6, and pick the appropriate factor based on the member's three-digit zip code and enter it on the rating sheet. The same factor will be used in the in the participating provider columns and the non-participating provider columns for both Pediatric and Adult plans.

Step 10: Provider Usage Factor: Refer to TABLE-7, and enter the provider usage factors in the appropriate columns.

Step 11: Out-of-Pocket Maximum Factor: The Pediatric dental benefit has an annual Out-of-Pocket Maximum of $700 for an individual up to a limit of $1,400 for the family priced into the Pediatric dental product and has a factor of 1.00 in the rating worksheet. If a $1,000 Out-of-Pocket Maximum for an individual up to a limit of $2,000 for the family members up to the age of 19 is used, a factor of .975 is used for the Out-of-Pocket Maximum factor line in the Pediatric columns in the rating worksheet.

Step 12: Family Factor: Enter the appropriate Family Factor from TABLE-8 depending on the product that is purchased. For purchasers of an Anthem Dental Family product, the Family Factor is to account for administrative efficiencies and decreased anti-selection risk of a family purchasing instead of individual purchasers of separate Pediatric and Adult policies.

Step 13: On the line labeled "Total Claim Cost", enter the product of multiplying the combined claim cost from step 3 by the factors in steps 4 through 12.

Step 14: Retention: Enter 1 minus the retention amount from TABLE-9. The expected loss ratio for this product is 70.54% for On-Exchange and Off-Exchange.

Step 15: On the line labeled "Gross Monthly Premium": enter the result of dividing the amount from step 13 by the amount in step 14.

Step 16: Blended Premium: To determine the blended premium rate, add the results from step 14, for the Participating Provider column, and the Non-Participating Provider column. Do this for both the Pediatric and Adult columns.

Step 17: Ortho Premium: The orthodontia premium is calculated in Exhibit 5. Dentally Necessary Orthodontia is included in all Pediatric plans and is the Pediatric class IV claim cost. This amount should be entered into the line 1 of Exhibit 5 under the Pediatric column. For the Anthem Dental Family Enhanced product, cosmetic orthodontia is included for members age 8 up to age 19 and the claim cost of the cosmetic orthodontia is located in TABLE-10 and entered in line 2 of Exhibit 5 in both the Pediatric and Adult columns. The sum of the costs for the Pediatric and Adult costs are entered in line 3 of Exhibit 5. In line 4 of Exhibit 4, enter 1 minus the retention percentage from TABLE-9. In Exhibit 5, line 5 equals

line 3 divided by line 4 to give the orthodontia premium amount to enter for the Orthodontia Premium in the rating worksheet.

Step 18: Final Premium Rates: Enter the sum of the Blended Premium Rate and Ortho Premium from step 16 and step 17 and enter into the Final Premium Rate for both the Pediatric and Adult columns.

Step 19: For the Anthem Dental Pediatric and Anthem Dental Adult products, the rates from step 18 are the rates to use multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. For the Anthem Dental Family products, Exhibit 3 is used to calculate the number of pediatric and adult premiums that will be rated for based on the makeup of the family, and the resulting values from Exhibit 3 are used in the Rating Worksheet for the Number of Pediatric Premiums and the Number of Adult Premiums, respectively. The Total Contract Premium is calculated by multiplying the rates in the Pediatric column from step 18 by the Number of Pediatric Premiums and adding the product of the Final Premium Rate in the Adult column from step 18 and the Number of Adult Premiums.

TABLE - 1A
Pediatric Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.1111	1.020	100%	2.000	1.050	100%	2.000	1.100
90%	1.0000	1.000	80%	1.600	1.041	50%	1.000	1.000
80%	0.8889	0.990	60%	1.200	1.010			
70%	0.7778	0.980	50%	1.000	1.000			

Default plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4A for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 1B
Adult Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.0000	1.000	90%	1.800	1.046	60%	1.200	1.030
90%	0.9000	0.993	80%	1.600	1.026	50%	1.000	1.000
80%	0.8000	0.992	60%	1.200	1.005	30%	0.600	0.965
75%	0.7500	0.988	50%	1.000	1.000	25%	0.500	0.955
50%	0.5000	0.970	30%	0.600	0.974	15%	0.300	0.945
			25%	0.500	0.964	0%	0.000	0.000
			15%	0.300	0.944			
			0%	0.000	0.000			

Default plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4B for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 2

Benefit Year Deductible Factors

	Factor
Deductible does not apply to Diagnostic and Preventive Services	1.00
Deductible does apply to Diagnostic and Preventive Services	0.95

Note:
A $50 per person deductible will apply to any Adult benefit set. The only variable regarding the deductible is whether or not the deductible applies to Diagnostic and Preventive Services. A $50 deductible applies to non-D&P services for Pediatric plans.

TABLE - 3

Annual Maximum Benefit Factors

Annual Maximum Amount	Factor
$500	0.9100
$750	0.9400
$1,000	0.9690
$1,200	1.0000
$1,250	1.0078
$1,500	1.0600
$1,750	1.0950
$2,000	1.1300
$2,500	1.2200

Note: For a quote that has D & P coverage only, annual maximum factors for all amounts equals amounts equals 1.00. Pediatric plans do not have an annual max therefore have a factor of 1.00 because the unlimted maximum is built into the starting claim cost.

TABLE - 4

Geographic Area Adjustment

Rating Area	Factor
Statewide	1.020

TABLE - 5

Benefit Waiting Period Factors

Services Covered	Factor
6 month waiting period on Basic Restorative and 12 month on non-D&P	0.975
12 month waiting period on Class III Only	1.000
Class I, Class II, and Class III are all covered with no waiting period	1.050

Note: Pediatric plans do not have waiting periods on non-orthodontia services therefore get a factor of 1.00.

TABLE - 6

Reimbursement Factors

Rating Area - Three-Digit Zips Included	Factor
Statewide	
Prime Network Reimbursement Factor	0.700
Non-Participating Reimbursement Factor	0.700

TABLE-7

Provider Usage Factors

Rating Area - Three-Digit Zips Included	**Factor**
Statewide	
Prime Network Usage Factor	0.507
Non-Participating Usage Factor	0.493

TABLE - 8

Family Factor

Product	**Factor**
Anthem Dental Pediatric Products	1.0000
Anthem Dental Adult Products	1.0000
Anthem Dental Family Products	0.9750

TABLE - 9

Retention Factor

	Retention as % of Premium	
	On-Exchange	Off-Exchange
Administration Expense	12.00%	12.00%
Premium Tax	1.00%	1.00%
ACA Insurer Fee	2.46%	2.46%
Exchange Fee	0.00%	0.00%
Commission	8.00%	8.00%
Profit / Risk Charge	6.00%	6.00%
Retention	**29.46%**	**29.46%**

TABLE - 10

Orthodontia Claim Costs

Orthodontia Benefit	**Claim Cost**
Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.36
Cosmetic Orthodontia per member per month cost $1,000 Lifetime Maximum with 12 Month Waiting Period Costemic Orthodontia is all orthodontia cases not deemed Dentally Necessary Orthodontia	$3.65
Dentally Necessary with no cost share for AV calculation Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.54

Exhibit 1 -- Individual Dental Rating Worksheet

Name	Product
Location (Zip Code)	Effective Date

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1												
Adjusted starting claim cost		Product of above 2 lines												
Combined Claim Cost		Sum of the 3 Classes												
Deductible adjustment		Refer to TABLE-2												
Annual maximum adjustment		Refer to TABLE-3												
Geographic area adjustment		Refer to TABLE-4												
Annual trend		Refer to Step 7												
Benefit waiting period factor		Refer to TABLE-5												
Reimbursement factor		Refer to TABLE-6												
Provider Usage factor		Refer to TABLE-10												
Out-Of-Pocket Max Factor		Refer to Step 11												
Family Factor		Refer to TABLE-8												
Total Claim Cost		Product of Combined Claims Cost factors and adjustments												
Retention	29.46%	Refer to TABLE-9	70.54%			70.54%			70.54%			70.54%		
Gross Monthly Premium		Total claim cost divided by (1 - Retention)	$0.00			$0.00			$0.00			$0.00		

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program		
Non-Participating Program		
Total	**$0.00**	**$0.00**

Ortho Premium	Refer to Exhibit 4 and Step 17	Pediatric	Adult
Total			

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total			

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total				**$0.00**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name	J. Doe
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6500	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.0200	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-10		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 4 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 3 -- Anthem Dental Family Product -- Number of Rates Worksheet

Name	J. Doe
Product	Anthem Dental Family Enhanced

Number of members in family	6
Number of non-child members (a)	2
Number of child members age 19 and older (b)	2
Number of child members under age 19 (c)	2

Number of non-child members to be rated (d):	2
Take the number (a)	
Number of children age 19 and older to be rated (e):	2
Take the lesser of (b) and 3	
Number of children age under age 19 to be rated (f)	1
Take the lesser of 3 minus (d) or (c)	

Number number of adult premiums rated	**4**
Take the sum of (d) and (e)	
Number of pediatric premiums to be rated for (f)	**1**

Exhibit 4A -- Pediatric Dental Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	90	50	50	50
3 Claim Impact Factors (Table-1)	1.111	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0200	1.0410	1.0000	1.0000
5 Total Change	1.1333	1.6656	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.6260	0.3740	1.0000
7 Total Weighted Change	1.1333	1.0427	0.3740	1.0000
8 Coinsurance Factor for Exhibit1	1.1333	1.4167		1.0000

Baseline plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 4B -- Adult Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	100	50	50	50
3 Claim Impact Factors (Table-1)	1.000	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0000	1.0260	1.0000	1.0000
5 Total Change	1.0000	1.6416	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.5283	0.4717	1.0000
7 Total Weighted Change	1.0000	0.8673	0.4717	1.0000
8 Coinsurance Factor for Exhibit1	1.0000	1.3390		1.0000

Baseline plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 5 -- Orthodontia Premium Worksheet		
Product		
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)		
Cosmetic Orthodontia (line 2)		
Total Orthodontia Claim Cost (line 3)		
Retention (line 4)		
Orthodontia Premium (line 5)		

Exhibit 6 -- Orthodontia Premium Worksheet -- Sample Calculation		
Product	Anthem Dental Family Enhanced	
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)	$0.39	$0.00
Cosmetic Orthodontia (line 2)	$3.65	$3.65
Total Orthodontia Claim Cost (line 3)	4.04	3.65
Retention (line 4)	70.54%	70.54%
Orthodontia Premium (line 5)	5.73	5.17

Exhibit 7

Development and Justification for Administrative Expense Load and Commission Load

Colorado Prime Network Products

These Prime Network dental products are administered by DeCare Dental which is a wholly owned subsidiary of WellPoint Inc. Anthem Blue Cross Blue Shield of Colorado is also a subsidiary of WellPoint Inc.

ADMINISTRATIVE EXPENSE

(a)	DeCare Dental administers a large block of small group dental risk products. Total incurred costs for administrative expenses for 2010 for the small group dental risk business administered by DeCare dental was:	$19,279,150
(b)	Total earned premium for 2010 for the small group dental risk business administered by DeCare Dental and mentioned in (a) above was:	$126,399,305
(c)	Incurred administrative costs as a percent of earned premium for 2010 for DeCare Dental's small group dental risk business was (a)/(b) which equals:	15.25%
(d)	Average annual premium per member per month (PMPM) for the small group dental business administered by DeCare Dental:	$24.43
(e)	Average monthly premium per member per month (PMPM) for the HCR compliant Prime Network business expected in Colorado:	$30.87
(f)	Ratio of average premium PMPM for DeCare small group business to expected average PMPM premium for Colorado Prime Network HCR business, equals (d) / (e):	0.791
(g)	Since the average expected Colorado dental premium is greater than the average DeCare small group dental premium, a lower percent of premium is needed to generate the needed administrative expense to operate the CO small group Prime % Complete business. That percentage is equal to (f) x (c) which equals:	12.07%

Anthem Blue Cross Blue Shield (BCBS) of Colorado does have a block of small group dental risk business. Below is some data regarding that business.

COMMISSION EXPENSE

(a)	Earned premium for 2012 for Anthem BCBS of Colorado small group dental business:	$5,229,195
(b)	Incurred commissions for 2012 for Anthem BCBS small group dental business:	$550,514
(c)	Ratio of commissions to premium for 2012 for Anthem BCBS small group dental	10.53%

(d) The 10.53% commission percentage above is a result of the commissions that were paid for Anthem BCBS's small group dental business in 2012. Generally most of the products have a 10% commission for the writing agent, and there are a few agreements in place in which a managing general agent receives a commission override. So, the commission in (c) above is made up of a 10% writing agent commission and a .43% commission override.
For the new Prime Network dental products, some of the sales will be made directly by the consumer without any compensation paid to a broker or a navigator, thereby having no commission expense. With this in mind, we are expecting an average commission rate for these HCR compliant products to be sold on and off exchange to be 8%.

Rocky Mountain Hospital and Medical Services, Inc.
Actuarial Memorandum
Anthem Dental Rate Manual

A. Summary

Reason(s) for the rate filing
This is a new rate filing.

Requested Rate Action
No rate action requested as this is a new rate filing and there is no historical data.

Marketing method(s)
This product will be marketed and sold On Exchange and Off Exchange by licensed brokers, via the internet and direct response to groups and individuals and their families residing in Colorado. It will be administered by DeCare Dental which is a licensed dental administrator.

Premium classification
Premiums for this product will vary by the following criteria: Benefits covered (coinsurance amounts, annual maximum benefits on adult benefits, deductibles, etc), age of the member which dictates the type of benefits available.

Product descriptions
This dental contract provides a variety of dental benefits that can be provided by an Anthem contracted provider, or a non-contracted provider. A detailed description of the benefit options may be found in the contract filing. In addition, a brief summary of the dental benefits is provided on page 2 of the rate manual portion of this rate filing.

Policy/Rider form
The memorandum address the following policy/rider forms

- Small Group policies:
  - 13-03271.06-SG-EX
  - 13-03271.06-SG
- Individual policies:
  - 13-03281.06-IND-EX
  - 13-03281.06-IND

Age basis
Members with an issue age below 19 will receive pediatric premiums associated with those benefits. Members with an issue age 19 and older will receive adult premiums associated with those benefits. All renewals will use the renewal age to set premiums.

Renewability provision
This product is guaranteed renewable.

B. Assumption, Acquisition or Merger

The product in this rate filing was not part of an assumption, acquisition, or merger with another company.

C. Rating Period

The rating period for this product and rate filing covers a one year period. The effective date, or the starting date, will be January 1, 2014, and the end date will be one year after the effective date. In addition, the effective date will not be before the approval date of this rate filing by the Colorado Department of Insurance.

D. Underwriting

The insured's application denotes the selected product, and effective date of coverage. An insured that cancels the Anthem dental plan cannot re-enroll for two years.

E. Effect of Law Changes

Not Applicable

F. Rate History

This is a new product and a new rate filing, therefore there is no prior rate history.

G. Coordination of Benefits

All coordination of benefit savings has been reflected in the baseline starting claims cost.

H. Relation of Benefits to Premium

The premiums are determined by developing the claims costs based on benefit design and group or individual's demographics and then dividing that number by the 1 minus the retention. TABLE-9 (given below) details each specific component of the retention load. These expenses are based on anticipated needs of Colorado-specific business. The anticipated retention is 29.46% and therefore the loss ratio is 70.54% which is well above the minimum of 60% set forth in CO regulation 4-24-11, section 6.H.3.b.

Retention Components	**On-Exchange**	**Off-Exchange**	**Explanation**
Administration Expense	12.00%	12.00%	*See Exhibit 7
Premium Tax	1.00%	1.00%	CO Statute
ACA Insurer Fee	2.46%	2.46%	Federal Fee
Exchange Fee	0.00%	0.00%	0 cost
Commission	8.00%	8.00%	*See Exhibit 7
Profit / Contingency	6.00%	6.00%	*See Section J
Retention	**29.46%**	**29.46%**	

I. Lifetime Loss Ratio

The products included in this rate filing were not priced using a lifetime loss ratio standard.

J. Provision for Profit and Contingencies

The Provision for Profit and Contingencies is set at 6% - below the 7% maximum outlined in CO regulation 4-24-11, section 6.J. This 6% is factored into retention to allow for accumulation of fund surplus and reserves necessary for Anthem BCBS to have adequate funds on hand to provide for unexpected claim volatility and fluctuations.

K. Complete Explanation as to How the Proposed Rates were Determined

Please refer to the the Dental Rate Manual that is attached to this memorandum

L. Trend

The starting claim costs were developed for an effective mid-point date of July 1st, 2012. The trend formula is (1 + (trend %/100))^ ((mid-point of rating period – July 1, 2012 expressed in integer half months)/24). Starting July 1st, 2012, claim costs are expected to increase at a trend of 5.00% annually in half-month increments. Premium rates will be guaranteed for 12 months, but for purposes of new sales, will change annually using the middle of the rating period to calculate the trend amount. For example, the January 1st, 2014 to December 31st, 2014 uses a rating period midpoint of June 30th, 2014 in calculating the trend amount.

The 5% trend assumption is composed of the following 3 components

- Utilization: 1.5% increase in services per exposure because of the expectation that the influx of previously uninsured will utilize more than the average person in year 1
- Unit cost: 2.0% increase in submitted charges from dental providers because the dental CPI is forecasted to increase more than 3% due to economic improvements and pent up demand to increase prices – this will mostly impact the non-participating provider
- Service Mix: 1.5% increase due to influx of the uninsured that will need more intense (Basic) services than the average policyholders.

M. Credibility

Not applicable since the rates are not determined using claims experience.

N. Data Requirements

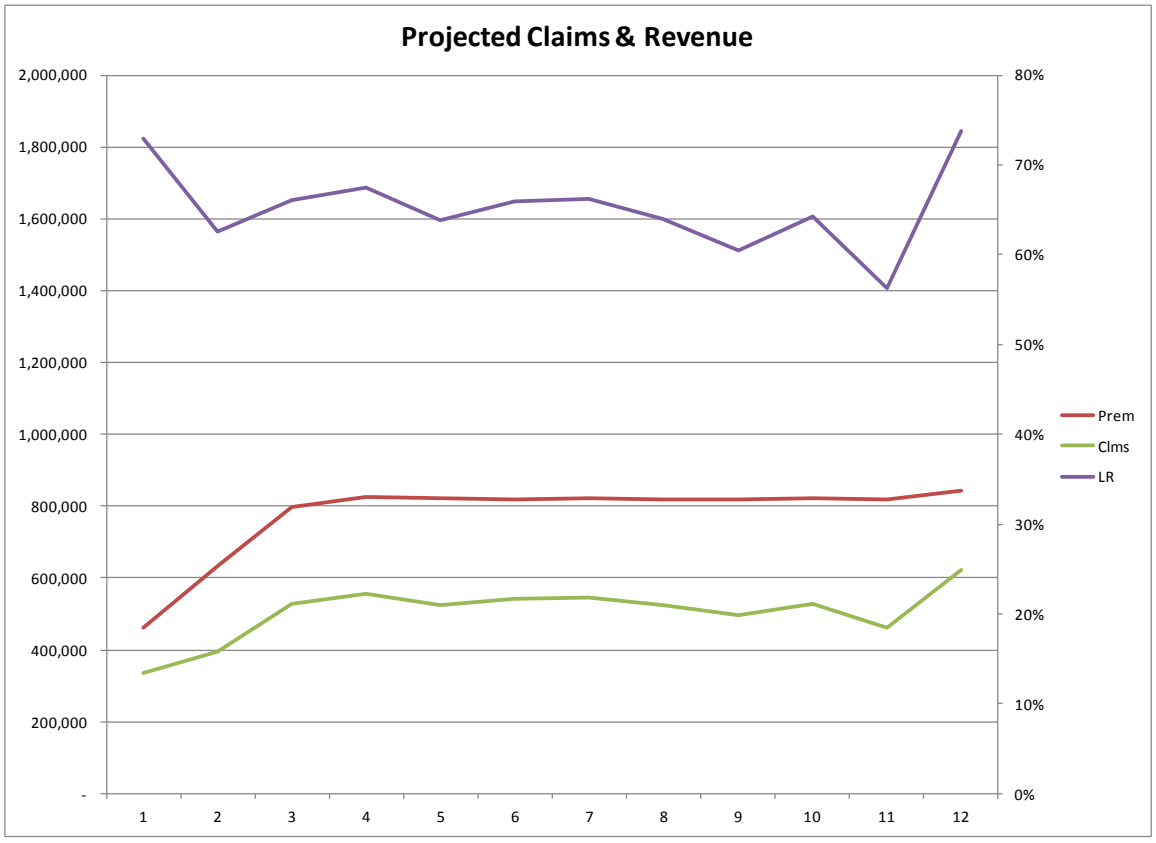
This is a new product and thus there are no earned premiums, incurred claims, actual benefits ratios, number of claims, average covered lives and number of policyholders to submit on a Colorado-only basis for at least 3 years.

O. Side-by-Side Comparison

This is a new product and thus there is nothing that can be compared.

P. Benefits Ratio Projections

The following is the 2014 projection of incurred claims, revenue and benefit loss ratios. Note that this is a new filing and there is no rate change request.



Q. Other Factors

Please refer to the information below and the Dental Rate Manual that is attached to this memorandum

The purpose of this filing is to demonstrate compliance with minimum requirements of the state of Colorado and show that the benefits are reasonable in relation to premiums charged.

This Anthem Blue Cross and Blue Shield (Anthem BCBS) Anthem Dental Rate Manual applies to the Anthem Dental Pediatric/Adult/Family products which are HCR compliant. This rate manual applies to rates that are being used and developed on behalf of Rocky Mountain Hospital and Medical Services, Inc, also doing business as Anthem BCBS. This rate manual applies to Small Group policies 13-03271.06-SG-EX & 13-03271.06-SG, Individual policies 13-03281.06-IND-EX, and 13-03281.06-IND. Individuals will be able to select plans with a range of benefit design options. This rate manual and the rates developed by it will be effective January 1st, 2014.

The rating method begins with starting claim costs. Factors are then applied to these costs that develop rates based on the member's benefit plan. The methodology will use linear interpolation to derive the appropriate factors for benefits not explicitly stated in this rate manual. The rating steps are shown in the two rating worksheets in the back of the Anthem BCBS Anthem Dental Rate Manual. Exhibit 1 shows the rating worksheet template, and Exhibit 2 shows a sample rate calculation.

Definitions

Class of Dental Services
Class I – Diagnostic and Preventive
Class II – Basic services; simple restorations, periodontics, endodontics and oral surgery
Class III – Major restorative services; prosthodontics and prosthetics
Class IV – Orthodontics; Dentally Necessary Orthodontics

Pediatric – Pediatric EHB Mandated Dental Benefits for individuals up to the age of 19
Adult – Dental Benefits for individuals age 19 and over
Family – Pediatric and Adult benefits purchased as a single contract. Individuals up to the age of 19 receive Pediatric benefits and individuals age 19 and over receive Adult benefits.
AV – Actuarial Value measured using benefits when using a participating provider represents the percentage of costs covered by the plan

Plan Offerings

Anthem Dental Pediatric Plan – Pediatric dental benefit with 70% AV
Anthem Dental Pediatric Enhanced Plan – Pediatric dental benefit with 85% AV
Anthem Dental Adult Plan – Adult dental benefit
Anthem Dental Adult Enhanced Plan – Adult dental benefit with higher coinsurance levels
Anthem Dental Family Plan – A combination of Anthem Dental Pediatric Plan and Anthem Dental Adult Plan with benefits based on the age of family members
Anthem Dental Family Enhanced Plan – A combination of Anthem Dental Pediatric Enhanced Plan and Anthem Dental Adult Enhanced Plan with benefits based on the age of family members; includes cosmetic orthodontia for children from age 8 up to age 19

Morbidity

The starting claim cost for each class of service (Diagnostic & Preventive, Basic, Major, and Orthodontics) is based on analyses of several recent years of claim data. An extensive claim database was used to derive this experience. This data is supplemented as needed by data provided by Milliman USA, an Actuarial Consulting firm.

Analyses were conducted separately for each of the following services: diagnostic and preventive, basic restorative, periodontic, endodontic, oral surgery, major restorative, prosthodontics, prosthetic repairs and orthodontics. The results were then aggregated into Class I, Class II, Class III and Class IV services.

The starting claim costs are developed assuming reimbursement at the full amount of the dentist submitted charge, where the dentist submitted charge is equal to a national average. The starting claim costs experience has a midpoint date of July 1, 2012.

The monthly starting Pediatric and Adult benefit claim costs are:

	Pediatric	Adult
Class I Diagnostic and Preventive Services	$13.10	$19.29
Class II Basic Services	$ 3.85	$11.79
Class III Major Services	$ 0.17	$ 8.25
Class IV Orthodontic Services	$ 0.39	$ 0.00

The Adult plans starting claim costs assume coinsurance levels of 100% for Class I services, 50% for Class II services, 50% for Class III services, a $50 per person deductible and a $1,200 annual maximum. The specific procedures defined by the PPACA Stand-Alone Dental Plan Procedures for Colorado dated May 31, 2013 are the only procedures covered in the Pediatric starting claim costs. The Pediatric starting claim costs assume coinsurance levels of 90% for Class I services, 50% for Class II services, 50% for Class III services, and also include Class IV Orthodontic Services as Dentally Necessary Orthodontia assuming a coinsurance level of 50%. All Pediatric plan starting claim costs assume no annual maximum and an out-of-pocket maximum of $700 per member up to a maximum of $1,400 per family. The pediatric plans also include a $50 deductible for non-Diagnostic & Preventive services which is included in the starting claim costs. TABLE-1 (see Rate Manual for Tables TABLE-1 through TABLE-10 referenced in this Actuarial Memorandum) lists the coinsurance percentages being offered and their corresponding adjustment factors for each of the three classes of services to reflect the differences from the coinsurance levels used to establish the starting claim costs. Due to the out-of-pocket maximum on the pediatric benefit, Class IV claim costs will not change with varying coinsurance.

Pediatric EHB Actuarial Value

The model used to develop the Actuarial Value (AV) for the pediatric EHB plans was comprised of dental claims data of members under the age of 19. The data was used to develop annual utilization by procedure code for all covered services under the pediatric EHB while including utilization adjustments for non-traditional benefits such as no annual max and an annual out-of-pocket maximum. Average allowed amounts by procedure were used to establish a total claim costs by benefit category for In-Network claims. Coinsurance levels where then determined by benefit category, defined as Class I through Class V in the preceding paragraph, and the ratio of the resulting claim costs with coinsurance to the total claim costs with 100% coverage is then verified to be within the AV of 70% plus or minus 2% or 85% plus or minus 2%.

Actuarial Value Calculation

The Actuarial Value (AV) calculation is determined as the ratio of the EHB claim costs of a certain benefit set in comparison to the claim costs of 100% coverage of the same benefits for In Network providers. The starting claim costs are adjusted for necessary coinsurance adjustments by pediatric benefit class using Table 1A. The table below shows the AV calculation for the Anthem Dental Pediatric Plans.

Benefit Class	Starting Claim Cost	Anthem Dental Pediatric	Anthem Dental Pediatric Enhanced	100% Coverage w/no deductible
Class I	$13.10	$13.10	$14.85	$15.31
Class II	$3.85	$3.85	$5.45	$8.34
Class III	$0.17	$0.17	$0.17	$0.39
Class IV	$0.36	$0.36	$0.36	$0.54
Total Claim Cost	$17.48	$17.48	$20.83	$24.57
Actuarial Value		**71.2%**	**84.8%**	

Mortality

Not Applicable

Persistency

Not Applicable

Premium Modalization Rules

Not Applicable

Claim Liability and Reserves

Incurred but not paid (IBNP) reserves which includes an amount for claim amounts reported but not yet paid will be established using a lag factor approach. This method uses claim payment histories to estimate the amount of claims that have been incurred in a particular time period. From the incurred amount, the actual paid amount is subtracted to get the IBNP reserve.

Active Life Reserves

Not Applicable, there are no active life reserves for this product.

Coinsurance Adjustment

Coinsurance amounts may be equal for benefits provided by participating providers, or they may differ depending on whether the member gets services from a participating or a non-participating provider. Additionally, coinsurance amounts may differ between Pediatric and Adult plans. To determine the coinsurance adjustment factors that apply to a given product option, refer to TABLE-1.

Deductible Adjustment

Deductibles, if present, are $50 per person per benefit year. Deductible factors are applied to Adult plan claim costs. The benefit year deductible can either apply to diagnostic and preventive services, or it can be waived for diagnostic and preventive services. Factors for the two deductible options are found in TABLE-2. Pediatric plans are subject to a $50 deductible on non-Class I services.

Annual Maximum Adjustment

The annual maximum for each person can be between $500 and $2,000 per benefit year. Adjustment factors are shown in TABLE-3. Pediatric benefits do not have an annual maximum amount on participating provider benefits and a $1,000 annual max on non-participating provider benefits which is reflective in the Pediatric starting claim costs.

Dependent Age Adjustment

Dependents are children of the individual. All product options assume that children of enrolled individuals are covered up to age 26, regardless if they are a student or not.

If the dependent child is under the age of 19, they will have a Pediatric EHB dental benefit plan design. If the dependent child is between the ages of 19 up to age 26, they will receive an Adult dental benefit plan design. Dependent coverage up to age 26 is assumed in the starting claims cost, so no claim factors are needed for this pricing assumption.

Geographic Area Adjustment

Anthem BCBS only markets to individuals who reside in the state of Colorado. This rating model does not use different geographic areas within Colorado, therefore the rates developed in this model are used for the entire state of Colorado. Given that rates apply to the entire state, one geographic area adjustment factor is used for all rates.

The Geographic Area Adjustment varies by rating area and is in TABLE-4.

Occupational Adjustment

An occupational adjustment factor is not used in this rating model.

Prior Coverage

These Anthem Dental products may have waiting periods for Class II and Class III services for Adult plans, as discussed below. In some circumstances, if the individual purchaser has had prior comparable coverage, waiting periods will be waived. However, prior coverage is not a pricing variable used in the pricing model. There is no waiting period for Pediatric EHB benefits.

Benefit waiting period factor

Certain Adult plans may have waiting periods before certain categories of services will be covered under the plan. These waiting periods can apply to basic services, major services. If applicable, the waiting period for basic services will be 6 months, and the waiting period for major services will be 12 months. For purposes of waiting periods, Endodontic, Periodontic, and Oral Surgery services are included in major services and have a 12 month waiting period. The Pediatric EHB benefit does not have any waiting periods on services other than dentally necessary orthodontia, which has a 12 month waiting period which is figured into the

orthodontia starting claim cost. The appropriate adjustment for claims cost can be found in TABLE-5.

Reimbursement

The assumed level of provider reimbursement in the starting claims cost is set at the average of national dental submitted charges. The allowed reimbursement for the Anthem Dental Pediatric/Adult/Family products are the same whether or not the member sees a participating provider or a non-participating provider. The reimbursement adjustment factors for the Anthem Dental Pediatric/Adult/Family products are found in TABLE-6.

Orthodontia

Dentally necessary orthodontia is part of the Pediatric EHB benefit. When a non-participating provider is used, there is a $1,000 Lifetime Maximum benefit. There is no Lifetime Maximum benefit when a participating provider is used. Supplemental cosmetic child orthodontia is included for family purchasers that select the Anthem Dental Family Enhanced Plan for child dependents age 8 up to age 19.

Retention

Retention is a percentage of gross premiums and includes administrative expense, profit and Contingency, and premium tax as required. The retention table is shown in TABLE-9. The retention also includes provision for a writing agent commission as well as a commission override if applicable. The retention breakout differs between products sold On-Exchange and Off-Exchange, however the total retention is equivalent to achieve the same price as shown in TABLE-9.

Expected Loss Ratio

The expected loss ratio for this product is 70.54%. This equals 100% less the retention percentage.

Premium

The Anthem Dental Rating Worksheet (Exhibit 1) yields per member per month rates. The maximum number of child dependents that premiums would be collected for is three as determined by Exhibit 3. The premium for the Anthem Dental Family product is the sum of the individual premiums of the Pediatric and Adult benefits multiplied by the Family Factor.

Provider Usage Factor

The Anthem Dental Pediatric/Adult/Family products use the Anthem Prime network. Provider usage factors for the Anthem Dental Pediatric/Adult/Family products are shown in TABLE-7. The factor which applies to participating providers, and the inverse, which applies to non-participating providers, will be applied respectively to determine the Participating Provider premium and the Non-Participating premium in the Rating Worksheet. The final premium rate is then the sum of the premiums for the participating provider benefits and the non-participating provider benefits.

I, Robert L. Mikkelsen, Chief Actuary, am employed with the firm DeCare Dental L.L.C. I am a Fellow of the Society of Actuaries, and a member of the American Academy of Actuaries. I meet the Academy's Qualification Standards of Actuarial Opinion.

To the best of my knowledge, this rate filing is in compliance with applicable laws and regulations of the state of Colorado, and with the rules of the Insurance Department. I certify that the rates are not excessive, inadequate or unfairly discriminatory. I also certify that the rates are reasonable in relation to the benefits provided. The actuarial methods, considerations and analysis used in forming my opinion conform to the relevant Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

In addition, the actuarial methods, considerations and analysis used to develop the Actuarial Values conform to the relevant Actuarial Standards of Practice, and meet the requirements of the Affordable Care Act.

Robert L Mikkelsen

Robert L. Mikkelsen, F.S.A., M.A.A.A.
Chief Actuary

6/27/13

Date

Anthem Blue Cross Blue Shield

ANTHEM DENTAL RATE MANUAL

Anthem Dental Pediatric/Adult/Family Products

Table of Contents

Schedule of Benefits
The following schedules of benefits will be made available to individuals depending on the member's age. Note that the schedule of benefits, for the non-participating provider benefit schedule could be different than the participating provider benefit schedule. Also, the schedule of benefits could be different for Adult members and Pediatric members.

Anthem Dental Pediatric/Adult/Family

Adult Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative*	NC or 10% to 90%
Endodontics*	NC or 10% to 90%
Periodontics*	NC or 10% to 90%
Oral Surgery*	NC or 10% to 90%
Major Restorative*	NC or 10% to 60%
Prosthetic Repairs/Adjustments*	NC or 10% to 60%
Prosthetics*	NC or 10% to 60%
Orthodontics*	NC

* NC denotes no coverage

Individual Deductible	$50 per person
Family Deductible	$50 per person
Annual Maximum	$500 - $2,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Deductible levels available at $50 at the individual level.
Annual maximum available within the range in increments of $250.
Annual Out-Of-Pocket (OOP) Maximum is not available.

Pediatric Plan -

Benefits	Coinsurance Range
Diagnostic & Preventive	50% to 100%
Basic Restorative	50% to 90%
Endodontics	50% to 90%
Periodontics	50% to 90%
Oral Surgery	50% to 90%
Major Restorative	50% to 60%
Prosthetic Repairs/Adjustments	50% to 60%
Prosthetics	50% to 60%
Dentally Necessary Orthodontics	50% to 60%
Cosmetic Orthodontics*	NC or 50% to 60%

* NC denotes no coverage

Individual Deductible	$50
Family Deductible	$50 per person
Annual Maximum	N/A for Participating Providers; $1,000 for Non-Participating Providers
Annual Out of Pocket Maximum Individual/Family	$700/$1,400
Dentally Necessary Orthodontics Maximum	No Maximum for Participating Providers; $1,000 LT Max for Non-Participating Providers
Cosmetic Orthodontia Lifetime Maximum	$1,000

Coinsurance percentages available within the range in increments of 5% or 10%.
Annual Out-Of-Pocket (OOP) Maximum on Pediatric EHB plans of $700 per member up to a maximum of $1,400 per family.

Plan Options Available

- Cosmetic Orthodontia is included with the Anthem Dental Family Enhanced Plan for children age 8 up to age 19
- Annual OOP Maximum may be $1,000 per member up to a maximum of $2,000 per family

Individual Dental Rate Manual Instructions

All calculations can be completed in the following Anthem Dental Rating Worksheet (see Exhibit 1). Linear interpolation is to be followed to derive the appropriate factors for benefits not explicitly given in this rate manual.

Step 1: Fill in the benefit plan information: the Individual's name, the product selected, location, and the effective date of the contract. Note that the benefits may vary between the participating provider columns and the non-participating columns as well as between Adult and Pediatric columns. Note that 100/80/50 denotes coverage at 100% for Diagnostic and Preventive (Class I), 80% coverage for Basic Restorative (Class II), and 50% coverage for Major Restorative (Class III).

Step 2: Coinsurance Adjustment Coinsurance adjustment factors (see TABLE-1) are given for different combinations of services. Based on the plan's benefits, find the appropriate set of coinsurance adjustment factors in TABLE-1A & TABLE-1B for Pediatric and Adult benefits respectively, and enter them in the appropriate coinsurance adjustment worksheet (Exhibits 4A & 4B) and enter the results of coinsurance adjustment worksheet into the coinsurance adjustment row of the rating worksheet.

Step 3: Multiply the Adult and Pediatric starting claim cost by the appropriate coinsurance adjustment factor for each class of service. Enter the results on the line in Exhibit 1 labeled "Adjusted starting claim cost". On the line labeled "Combined claim cost" enter the sum of the Class I, Class II, and Class III adjusted starting claim costs.

Step 4: Enter the Deductible adjustment from TABLE-2. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to a deductible and that is reflected in the Pediatric starting claim costs.

Step 5: Based on the plans annual maximum benefit, enter the appropriate annual maximum adjustment factor from TABLE-3. For Pediatric plans, the factor is 1.0 because the Pediatric benefits are not subject to an annual max and that is reflected in the Pediatric starting claim costs.

Step 6: Geographic Area Adjustment: Refer to TABLE-4, and pick the appropriate factor based on the three-digit zip code the member resides in. Enter the factor on the rating sheet.

Step 7: Annual Trend The starting claim costs were developed with a baseline date of July 1, 2012. Claim costs are expected to increase at a trend of 5.00% annually in half month increments. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$. Enter the compounded trend amount on the annual trend line on the rating worksheet. For example if the quote applies to period of January 1st, 2014 to December 31st, 2014, the trend period is from July 1st, 2012 to June 30th, 2014 (the mid-point of the rating period), or 48 half months.

Step 8: For benefit plan designs that include waiting periods for certain benefit categories, the appropriate factor in TABLE-5 will be entered in the columns on the line labeled "Benefit Waiting Period factor". For Pediatric plans, the factor is 1.00 because the Pediatric benefits are not subject to waiting periods and that is reflected in the Pediatric starting claim costs.

Step 9: Reimbursement Factor: Refer to TABLE-6, and pick the appropriate factor based on the member's three-digit zip code and enter it on the rating sheet. The same factor will be used in the in the participating provider columns and the non-participating provider columns for both Pediatric and Adult plans.

Step 10: Provider Usage Factor: Refer to TABLE-7, and enter the provider usage factors in the appropriate columns.

Step 11: Out-of-Pocket Maximum Factor: The Pediatric dental benefit has an annual Out-of-Pocket Maximum of $700 for an individual up to a limit of $1,400 for the family priced into the Pediatric dental product and has a factor of 1.00 in the rating worksheet. If a $1,000 Out-of-Pocket Maximum for an individual up to a limit of $2,000 for the family members up to the age of 19 is used, a factor of .975 is used for the Out-of-Pocket Maximum factor line in the Pediatric columns in the rating worksheet.

Step 12: Family Factor: Enter the appropriate Family Factor from TABLE-8 depending on the product that is purchased. For purchasers of an Anthem Dental Family product, the Family Factor is to account for administrative efficiencies and decreased anti-selection risk of a family purchasing instead of individual purchasers of separate Pediatric and Adult policies.

Step 13: On the line labeled "Total Claim Cost", enter the product of multiplying the combined claim cost from step 3 by the factors in steps 4 through 12.

Step 14: Retention: Enter 1 minus the retention amount from TABLE-9. The expected loss ratio for this product is 70.54% for On-Exchange and Off-Exchange.

Step 15: On the line labeled "Gross Monthly Premium": enter the result of dividing the amount from step 13 by the amount in step 14.

Step 16: Blended Premium: To determine the blended premium rate, add the results from step 14, for the Participating Provider column, and the Non-Participating Provider column. Do this for both the Pediatric and Adult columns.

Step 17: Ortho Premium: The orthodontia premium is calculated in Exhibit 5. Dentally Necessary Orthodontia is included in all Pediatric plans and is the Pediatric class IV claim cost. This amount should be entered into the line 1 of Exhibit 5 under the Pediatric column. For the Anthem Dental Family Enhanced product, cosmetic orthodontia is included for members age 8 up to age 19 and the claim cost of the cosmetic orthodontia is located in TABLE-10 and entered in line 2 of Exhibit 5 in both the Pediatric and Adult columns. The sum of the costs for the Pediatric and Adult costs are entered in line 3 of Exhibit 5. In line 4 of Exhibit 4, enter 1 minus the retention percentage from TABLE-9. In Exhibit 5, line 5 equals

line 3 divided by line 4 to give the orthodontia premium amount to enter for the Orthodontia Premium in the rating worksheet.

Step 18: Final Premium Rates: Enter the sum of the Blended Premium Rate and Ortho Premium from step 16 and step 17 and enter into the Final Premium Rate for both the Pediatric and Adult columns.

Step 19: For the Anthem Dental Pediatric and Anthem Dental Adult products, the rates from step 18 are the rates to use multiplied by the number of members under the age of 19 up to a maximum of 3 for the Pediatric product or the number of members age 19 and over for the Adult product to show the total premium for the contract. For the Anthem Dental Family products, Exhibit 3 is used to calculate the number of pediatric and adult premiums that will be rated for based on the makeup of the family, and the resulting values from Exhibit 3 are used in the Rating Worksheet for the Number of Pediatric Premiums and the Number of Adult Premiums, respectively. The Total Contract Premium is calculated by multiplying the rates in the Pediatric column from step 18 by the Number of Pediatric Premiums and adding the product of the Final Premium Rate in the Adult column from step 18 and the Number of Adult Premiums.

TABLE - 1A
Pediatric Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.1111	1.020	100%	2.000	1.050	100%	2.000	1.100
90%	1.0000	1.000	80%	1.600	1.041	50%	1.000	1.000
80%	0.8889	0.990	60%	1.200	1.010			
70%	0.7778	0.980	50%	1.000	1.000			

Default plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4A for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 1B
Adult Dental Benefit
Coinsurance Adjustment Factor

Applies to Class I			Applies to Class II			Applies to Class III		
Class I Coinsurance	Claims Impact Factor	Utilization Factor	Class II Coinsurance	Claims Impact Factor	Utilization Factor	Class III Coinsurance	Claims Impact Factor	Utilization Factor
100%	1.0000	1.000	90%	1.800	1.046	60%	1.200	1.030
90%	0.9000	0.993	80%	1.600	1.026	50%	1.000	1.000
80%	0.8000	0.992	60%	1.200	1.005	30%	0.600	0.965
75%	0.7500	0.988	50%	1.000	1.000	25%	0.500	0.955
50%	0.5000	0.970	30%	0.600	0.974	15%	0.300	0.945
			25%	0.500	0.964	0%	0.000	0.000
			15%	0.300	0.944			
			0%	0.000	0.000			

Default plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins)
and measures the amount of change relative to default coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Refer to Exhibit-4B for an example of how to use TABLE-1 and develop factors to be used in the Individual Rating Worksheet.

TABLE - 2

Benefit Year Deductible Factors

	Factor
Deductible does not apply to Diagnostic and Preventive Services	1.00
Deductible does apply to Diagnostic and Preventive Services	0.95

Note:
A $50 per person deductible will apply to any Adult benefit set. The only variable regarding the deductible is whether or not the deductible applies to Diagnostic and Preventive Services. A $50 deductible applies to non-D&P services for Pediatric plans.

TABLE - 3

Annual Maximum Benefit Factors

Annual Maximum Amount	Factor
$500	0.9100
$750	0.9400
$1,000	0.9690
$1,200	1.0000
$1,250	1.0078
$1,500	1.0600
$1,750	1.0950
$2,000	1.1300
$2,500	1.2200

Note: For a quote that has D & P coverage only, annual maximum factors for all amounts equals amounts equals 1.00. Pediatric plans do not have an annual max therefore have a factor of 1.00 because the unlimted maximum is built into the starting claim cost.

TABLE - 4

Geographic Area Adjustment

Rating Area	Factor
Statewide	1.020

TABLE - 5

Benefit Waiting Period Factors

Services Covered	Factor
6 month waiting period on Basic Restorative and 12 month on non-D&P	0.975
12 month waiting period on Class III Only	1.000
Class I, Class II, and Class III are all covered with no waiting period	1.050

Note: Pediatric plans do not have waiting periods on non-orthodontia services therefore get a factor of 1.00.

TABLE - 6

Reimbursement Factors

Rating Area - Three-Digit Zips Included	Factor
Statewide	
Prime Network Reimbursement Factor	0.700
Non-Participating Reimbursement Factor	0.700

TABLE-7

Provider Usage Factors

Rating Area - Three-Digit Zips Included	**Factor**
Statewide	
Prime Network Usage Factor	0.507
Non-Participating Usage Factor	0.493

TABLE - 8

Family Factor

Product	**Factor**
Anthem Dental Pediatric Products	1.0000
Anthem Dental Adult Products	1.0000
Anthem Dental Family Products	0.9750

TABLE - 9

Retention Factor

	Retention as % of Premium	
	On-Exchange	Off-Exchange
Administration Expense	12.00%	12.00%
Premium Tax	1.00%	1.00%
ACA Insurer Fee	2.46%	2.46%
Exchange Fee	0.00%	0.00%
Commission	8.00%	8.00%
Profit / Risk Charge	6.00%	6.00%
Retention	**29.46%**	**29.46%**

TABLE - 10

Orthodontia Claim Costs

Orthodontia Benefit	**Claim Cost**
Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.36
Cosmetic Orthodontia per member per month cost $1,000 Lifetime Maximum with 12 Month Waiting Period Costemic Orthodontia is all orthodontia cases not deemed Dentally Necessary Orthodontia	$3.65
Dentally Necessary with no cost share for AV calculation Dentally Necessary Orthodontia per member per month claim cost Dentally Necessary Orthodontia has a 12 Month Waiting Period	$0.54

Exhibit 1 -- Individual Dental Rating Worksheet

Name	Product
Location (Zip Code)	Effective Date

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1												
Adjusted starting claim cost		Product of above 2 lines												
Combined Claim Cost		Sum of the 3 Classes												
Deductible adjustment		Refer to TABLE-2												
Annual maximum adjustment		Refer to TABLE-3												
Geographic area adjustment		Refer to TABLE-4												
Annual trend		Refer to Step 7												
Benefit waiting period factor		Refer to TABLE-5												
Reimbursement factor		Refer to TABLE-6												
Provider Usage factor		Refer to TABLE-10												
Out-Of-Pocket Max Factor		Refer to Step 11												
Family Factor		Refer to TABLE-8												
Total Claim Cost		Product of Combined Claims Cost factors and adjustments												
Retention	29.46%	Refer to TABLE-9	70.54%			70.54%			70.54%			70.54%		
Gross Monthly Premium		Total claim cost divided by (1 - Retention)	$0.00			$0.00			$0.00			$0.00		

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program		
Non-Participating Program		
Total	**$0.00**	**$0.00**

Ortho Premium (Refer to Exhibit 4 and Step 17)	Pediatric	Adult
Total		

Final Premium Rate (Refer to Step 18)	Pediatric	Adult
Total		

Final Total Premium Rate (Refer to Step 19)	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total			**$0.00**

Exhibit 2 -- Dental Rating Worksheet -- Sample Rate Calculation

Name	J. Doe
Location (Zip Code)	81612

Product	Anthem Dental Family Enhanced
Effective Date	1/1/2014 - 12/31/2014

			Pediatric Plan						Adult Plan					
			Participating Provider			Non-Participating Provider			Participating Provider			Non-Participating Provider		
	Factor	Reference	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III	Class I	Class II	Class III
Starting claim cost		Refer to Memo pg 2	$13.10	$3.85	$0.17	$13.10	$3.85	$0.17	$19.29	$11.79	$8.25	$19.29	$11.79	$8.25
Coinsurance adjustment		Refer to TABLE-1	1.1333	1.4167	1.0000	0.8800	1.1327	1.0000	1.0000	1.3387	1.0000	0.4850	0.6500	0.4775
Adjusted starting claim cost		Product of above 2 lines	$14.85	$5.45	$0.17	$11.53	$4.36	$0.17	$19.29	$15.78	$8.25	$9.36	$7.66	$3.94
Combined Claim Cost		Sum of the 3 Classes		$20.47			$16.06			$43.32			$20.96	
Deductible adjustment		Refer to TABLE-2		1.0000			1.0000			0.9500			0.9500	
Annual maximum adjustment		Refer to TABLE-3		1.0000			1.0000			0.9690			0.9690	
Geographic area adjustment	1.0200	Refer to TABLE-4		1.0200			1.0200			1.0200			1.0200	
Annual trend	1.1025	Refer to Step 7		1.1025			1.1025			1.1025			1.1025	
Benefit waiting period factor	1.0000	Refer to TABLE-5		1.0000			1.0000			1.0000			1.0000	
Reimbursement factor	0.7000	Refer to TABLE-6		0.7000			0.7000			0.7000			0.7000	
Provider Usage factor		Refer to TABLE-10		0.507			0.493			0.507			0.493	
Out-Of-Pocket Max Factor	1.0000	Refer to Step 11		1.000			1.000			1.000			1.000	
Family Factor	0.9750	Refer to TABLE-8		0.9750			0.9750			0.9750			0.9750	
Total Claim Cost		Product of Combined Claims Cost factors and adjustments		$7.97			$6.08			$15.52			$7.30	
Retention	29.46%	Refer to TABLE-9		70.54%			70.54%			70.54%			70.54%	
Gross Monthly Premium		Total claim cost divided by (1 - Retention)		$11.29			$8.61			$22.00			$10.35	

Blended Premium Rate (Two Tier Rates)	Pediatric	Adult
Participating Program	$11.29	$22.00
Non-Participating Program	$8.61	$10.35
Total	**$19.90**	**$32.35**

Ortho Premium	Refer to Exhibit 4 and	Pediatric	Adult
Total	Step 17	**$5.68**	**$5.17**

Final Premium Rate	Refer to Step 18	Pediatric	Adult
Total		**$25.58**	**$37.52**

Final Total Premium Rate	Refer to Step 19	Number of Pediatric Premiums	Number of Adult Premiums	Total Contract Premium
Total		**1**	**4**	**$175.66**

Exhibit 3 -- Anthem Dental Family Product -- Number of Rates Worksheet

Name	J. Doe
Product	Anthem Dental Family Enhanced

Number of members in family	6
Number of non-child members (a)	2
Number of child members age 19 and older (b)	2
Number of child members under age 19 (c)	2

Number of non-child members to be rated (d):	2
Take the number (a)	
Number of children age 19 and older to be rated (e):	2
Take the lesser of (b) and 3	
Number of children age under age 19 to be rated (f)	1
Take the lesser of 3 minus (d) or (c)	

Number number of adult premiums rated	**4**
Take the sum of (d) and (e)	
Number of pediatric premiums to be rated for (f)	**1**

Exhibit 4A -- Pediatric Dental Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	90	50	50	50
3 Claim Impact Factors (Table-1)	1.111	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0200	1.0410	1.0000	1.0000
5 Total Change	1.1333	1.6656	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.6260	0.3740	1.0000
7 Total Weighted Change	1.1333	1.0427	0.3740	1.0000
8 Coinsurance Factor for Exhibit1	1.1333	1.4167		1.0000

Baseline plan design assumes 90% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 4B -- Adult Benefit -- Coinsurance Adjustment Worksheet

	Class I	Class II		Class III
	D&P	Basic Restorative	Endodontics Periodontics & Oral Surgery	Major Restorative & Prosthodontics
1 Coinsurance Quoted	100	80	50	50
2 Coinsurance Baseline	100	50	50	50
3 Claim Impact Factors (Table-1)	1.000	1.600	1.000	1.000
4 Utilization Factor (Table-1)	1.0000	1.0260	1.0000	1.0000
5 Total Change	1.0000	1.6416	1.0000	1.0000
6 Proportion of Category Claims	1.0000	0.5283	0.4717	1.0000
7 Total Weighted Change	1.0000	0.8673	0.4717	1.0000
8 Coinsurance Factor for Exhibit1	1.0000	1.3390		1.0000

Baseline plan design assumes 100% - 50% - 50%.

Claims Impact Factor is defined as (Actual Coins/Default Coins) and measures the amount of change relative to baseline coinsurance.

Utilization Factor shows the amount of expected change in utilization patterns.

Enter the actual coinsurance amounts quoted on line 1 (Coinsurance Quoted). The Claims Impact Factor (line 3) and Utilization Factor (line 4) are entered from Table-1. The Total Change (line 5) is lines 4 and 6 multiplied together. The Total Weighted Change (line 6) is the product of lines 4 and 5. The final Coinsurance Factor (line 8) is the sum of line 7 for each procedure class.

Exhibit 5 -- Orthodontia Premium Worksheet		
Product		
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)		
Cosmetic Orthodontia (line 2)		
Total Orthodontia Claim Cost (line 3)		
Retention (line 4)		
Orthodontia Premium (line 5)		

Exhibit 6 -- Orthodontia Premium Worksheet -- Sample Calculation		
Product	Anthem Dental Family Enhanced	
	Orthodontic Rates	
	Pediatric	Adult
Dentally Necessary Orthodontia (line 1)	$0.39	$0.00
Cosmetic Orthodontia (line 2)	$3.65	$3.65
Total Orthodontia Claim Cost (line 3)	4.04	3.65
Retention (line 4)	70.54%	70.54%
Orthodontia Premium (line 5)	5.73	5.17

State Of Colorado

Health Rate Filing Form

Form HR-1

Reset Form

Must Be Completed For All Products SERFF FILING # ANTV-129075587

1. Company: Rocky Mountain Hospital and Medical Services, Inc., dba Anthem Blue Cross and E

2. Person Responsible For Filing: Robert L. Mikkelsen	3. Title: Actuarial Director
4. Address Of Responsible Person: 3560 Delta Dental D	5. Telephone #: (651) 406-5983 ext.

6. Email Address: robert.mikkelsen@wellpoint.com

7. **Type Of Coverage**: PPO Other :

8. Medicare Supplement: N/A Not Applicable ☑

(1) Prestandardized Plan(s):

(2) Standardized Plan(s): ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ FHD ☐ G ☐ H ☐ I ☐ J ☐ JHD ☐ K ☐ L

(3) 2010 Plans: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ FHD ☐ G ☐ K ☐ L ☐ M ☐ N

9. **Sub Category:** Small Group (1-50)

10. A. Group Information: Employer N/A N/A N/A

B. Name of association or trust *(if applicable)*:

C. Description of discretionary group*(if applicable)*:

11. **Colorado State Code(s)**: 701 Small Group N/A

N/A N/A N/A

12. **Brief Filing Description** (Disability, Major Medical, LTC, Etc. Also Describe All Methodology Changes.):

Small Group Dental PPO Product

13. **Reason For Filing:**	
Increase In Benefits?	☐ Yes ☑ No
Reduction In Benefits?	☐ Yes ☑ No
Increase in Profits?	☐ Yes ☑ No
Change Needed To Meet Projected Losses?	☐ Yes ☑ No
Trend Only?	☐ Yes ☑ No
Change In Rating Methodology?	☐ Yes ☑ No
New Product (Initial Offering As Opposed To Rate Revision)?	☑ Yes ☐ No
Other?	☐ Yes ☑ No
(If other, please explain)	

14. **Policy Form(s) Affected**: 13-03271.06-SG, 13-03271.06-SG-EX

15. If Rider Or Endorsement, **Type Of Benefits**? N/A

16. Closed Block(s)? ☐ Yes ☑ No Date Block Closed:

17. **Number Of Colorado Covered Lives** (Including Employees And Dependents): N/A

18. A. Rating Period: Annual From 10/1/2013 To 9/30/2013
B. Experience Period: From To
C. Reason for Rate Change:
D. Average Change In Rates From One Year Prior To Effective Date: 0.00%

☑ N/A (New Product)

19. A. **Rate Change Without Trend:** 0.00%
B. **Trend for Rating Period (if trend factor is used in rates):** 0.00%
C. Overall Rate Impact Change: 0.00%

20. A. **Current Underlying *Annualized* Trend Assumption** (If Applicable): 0.00%
B. Requested Underlying *Annualized* Trend Assumption (If Applicable): 0.00%

21. A. **What Is The Maximum Rate Change That Can Affect A Policyholder?** 0.00%
B. **What Is The Minimum Rate Change That Can Affect A Policyholder?** 0.00%

(If the selected rate change differs from the indicated rate change, please fully detail in the actuarial memorandum in section 6K.)

Benefits Ratios (**On Colorado only basis**)

22. A. Targeted Benefits Ratio over Rating Period (assumed in calculation of rates): 70.54%

B. Actual Benefits Ratio over Experience Period: 0.00%

☑ N/A (New Product)

23. A. **Projected Benefits Ratio With Rate Change over Rating Period** 0.00%
B. Projected Benefits Ratio **Without** Rate Change over Rating Period 0.00%

☐ Colorado
☐ Colorado/Nationwide
☐ Nationwide Basis

☑ N/A (New Product)

(If projected benefits ratios on a Colorado only basis are not available, then ratios developed on a blended Colorado/Nationwide or Nationwide basis are acceptable. Please indicate above.)

24. **Proposed Effective Date:** 10/01/2013

25. A. **Total Annual *Colorado* Written Premium Before Change(s)**: $
B. **Total Annual *Colorado* Written Premium After Change(s)**: $
C. Written Premium Change For This Product (Net Change): $

☑ N/A (New Product)

26. A. **Effective Date** of Previous Rate Filing for this Form (including initial filing):
B. Previous SERFF Filing Number(s):
C. Overall Percentage of Last Rate Change for Affected Policy Forms: 0.00%

☑ N/A (New Product)

27. **Experience Provided:** ☐ **Nationwide** ☐ **Colorado** Select One ☐ **other (specify)**

☑ N/A (New Product)

28. ***Small Group Filings Only*: Unique Single Index Rate** **(Effective For All Small Group Plans):**

When completed, please hit the button to the right and also attach to filing in SERFF. **SUBMIT TO DIVISION**

Rocky Mountain Hospital and Medical Services, Inc.
Actuarial Memorandum
Anthem Dental Rate Manual

Scope and Purpose of Filing

The purpose of this filing is to demonstrate compliance with minimum requirements of the state of Colorado and show that the benefits are reasonable in relation to premiums charged. This is a new rate filing.

This Anthem Blue Cross and Blue Shield (Anthem BCBS) Anthem Dental Rate Manual applies to the Anthem Dental Pediatric/Adult/Family products which are HCR compliant. This rate manual applies to rates that are being used and developed on behalf of Rocky Mountain Hospital and Medical Services, Inc, also doing business as Anthem BCBS. This rate manual applies to policy 13-03271.06-SG-EX, 13-03271.06-SG, 13-03281.06-IND-EX, and 13-03281.06-IND. Individuals will be able to select plans with a range of benefit design options. This rate manual and the rates developed by it will be effective January 1st, 2014.

The rating method begins with starting claim costs. Factors are then applied to these costs that develop rates based on the member's benefit plan. The methodology will use linear interpolation to derive the appropriate factors for benefits not explicitly stated in this rate manual. The rating steps are shown in the two rating worksheets in the back of the Anthem BCBS Anthem Dental Rate Manual. Exhibit 1 shows the rating worksheet template, and Exhibit 2 shows a sample rate calculation.

Definitions

Class of Dental Services
Class I – Diagnostic and Preventive
Class II – Basic services; simple restorations, periodontics, endodontics and oral surgery
Class III – Major restorative services; prosthodontics and prosthetics
Class IV – Orthodontics; Dentally Necessary Orthodontics
Pediatric – Pediatric EHB Mandated Dental Benefits for individuals up to the age of 19
Adult – Dental Benefits for individuals age 19 and over
Family – Pediatric and Adult benefits purchased as a single contract. Individuals up to the age of 19 receive Pediatric benefits and individuals age 19 and over receive Adult benefits.
AV – Actuarial Value measured using benefits when using a participating provider represents the percentage of costs covered by the plan

Description of Benefits

This dental contract provides a variety of dental benefits that can be provided by an Anthem contracted provider, or a non-contracted provider. A detailed description of the benefit options may be found in the contract filing. In addition, a brief summary of the dental benefits is provided on page 2 of the rate manual portion of this rate filing.

Plan Offerings

Anthem Dental Pediatric Plan – Pediatric dental benefit with 70% AV
Anthem Dental Pediatric Enhanced Plan – Pediatric dental benefit with 85% AV
Anthem Dental Adult Plan – Adult dental benefit
Anthem Dental Adult Enhanced Plan – Adult dental benefit with higher coinsurance levels
Anthem Dental Family Plan – A combination of Anthem Dental Pediatric Plan and Anthem Dental Adult Plan with benefits based on the age of family members
Anthem Dental Family Enhanced Plan – A combination of Anthem Dental Pediatric Enhanced Plan and Anthem Dental Adult Enhanced Plan with benefits based on the age of family members; includes cosmetic orthodontia for children from age 8 up to age 19

Morbidity

The starting claim cost for each class of service (Diagnostic & Preventive, Basic, Major, and Orthodontics) is based on analyses of several recent years of claim data. An extensive claim database was used to derive this experience. This data is supplemented as needed by data provided by Milliman USA, an Actuarial Consulting firm.

Analyses were conducted separately for each of the following services: diagnostic and preventive, basic restorative, periodontic, endodontic, oral surgery, major restorative, prosthodontics, prosthetic repairs and orthodontics. The results were then aggregated into Class I, Class II, Class III and Class IV services.

The starting claim costs are developed assuming reimbursement at the full amount of the dentist submitted charge, where the dentist submitted charge is equal to a national average. The starting claim costs experience has a midpoint date of July 1, 2012.

The monthly starting Pediatric and Adult benefit claim costs are:

	Pediatric	Adult
Class I Diagnostic and Preventive Services	$13.10	$19.29
Class II Basic Services	$ 3.85	$11.79
Class III Major Services	$ 0.17	$ 8.25
Class IV Orthodontic Services	$ 0.39	$ 0.00

The Adult plans starting claim costs assume coinsurance levels of 100% for Class I services, 50% for Class II services, 50% for Class III services, a $50 per person deductible and a $1,200 annual maximum. The specific procedures defined by the PPACA Stand-Alone Dental Plan Procedures for Colorado dated May 31, 2013 are the only procedures covered in the Pediatric starting claim costs. The Pediatric starting claim costs assume coinsurance levels of 90% for Class I services, 50% for Class II services, 50% for Class III services, and also include Class IV Orthodontic Services as Dentally Necessary Orthodontia assuming a coinsurance level of 50%. All Pediatric plan starting claim costs assume no annual maximum and an out-of-pocket maximum of $700 per member up to a maximum of $1,400 per family. The pediatric plans also include a $50 deductible for non-Diagnostic & Preventive services which is included in the starting claim costs. TABLE-1 (see Rate Manual for Tables TABLE-1 through TABLE-10 referenced in this Actuarial Memorandum) lists the coinsurance percentages being offered

and their corresponding adjustment factors for each of the three classes of services to reflect the differences from the coinsurance levels used to establish the starting claim costs. Due to the out-of-pocket maximum on the pediatric benefit, Class IV claim costs will not change with varying coinsurance.

Pediatric EHB Actuarial Value

The model used to develop the Actuarial Value (AV) for the pediatric EHB plans was comprised of dental claims data of members under the age of 19. The data was used to develop annual utilization by procedure code for all covered services under the pediatric EHB while including utilization adjustments for non-traditional benefits such as no annual max and an annual out-of-pocket maximum. Average allowed amounts by procedure were used to establish a total claim costs by benefit category for In-Network claims. Coinsurance levels where then determined by benefit category, defined as Class I through Class V in the preceding paragraph, and the ratio of the resulting claim costs with coinsurance to the total claim costs with 100% coverage is then verified to be within the AV of 70% plus or minus 2% or 85% plus or minus 2%.

Actuarial Value Calculation

The Actuarial Value (AV) calculation is determined as the ratio of the EHB claim costs of a certain benefit set in comparison to the claim costs of 100% coverage of the same benefits for In Network providers. The starting claim costs are adjusted for necessary coinsurance adjustments by pediatric benefit class using Table 1A. The table below shows the AV calculation for the Anthem Dental Pediatric Plans.

Benefit Class	Starting Claim Cost	Anthem Dental Pediatric	Anthem Dental Pediatric Enhanced	100% Coverage w/no deductible
Class I	$13.10	$13.10	$14.85	$15.31
Class II	$3.85	$3.85	$5.45	$8.34
Class III	$0.17	$0.17	$0.17	$0.39
Class IV	$0.36	$0.36	$0.36	$0.54
Total Claim Cost	$17.48	$17.48	$20.83	$24.57
Actuarial Value		**71.2%**	**84.8%**	

Mortality

Not Applicable

Persistency

Not Applicable

Requested Rate Action

As mentioned above, this is a new rate filing and thus develops initial rates for this new product and its various benefit options. There are no prior historical rates that can be used for comparison purposes.

Marketing Method
This product will be marketed and sold On Exchange and Off Exchange by licensed brokers, via the internet and direct response to groups and individuals and their families residing in Colorado. It will be administered by DeCare Dental which is a licensed dental administrator.

Premium Classification
Premiums for this product will vary by the following criteria: Benefits covered (coinsurance amounts, annual maximum benefits on adult benefits, deductibles, etc), age of the member which dictates the type of benefits available.

Policy / Rider Form
As mentioned above, this actuarial memorandum applies to Policy Forms 13-03271.06-SG-EX, 13-03271.06-SG, 13-03281.06-IND-EX, and 13-03281.06-IND.

Age Basis
Members under the age of 19 will receive pediatric benefits and premiums associated with those benefits. Members age 19 and older will receive adult benefits and premiums associated with those benefits.

Renewability Provision
This product is guaranteed renewable.

Assumption, Acquisition or Merger
The product in this rate filing was not part of an assumption, acquisition, or merger with another company.

Rating Period
The rating period for this product and rate filing covers a one year period. The effective date, or the starting date, will be January 1, 2014, and the end date will be one year after the effective date. In addition, the effective date will not be before the approval date of this rate filing by the Colorado Department of Insurance.

Underwriting
The insured's application denotes the selected product, and effective date of coverage. An insured that cancels the Anthem dental plan cannot re-enroll for two years.

Effect of Law Changes
Not Applicable

Rate History
This is a new product and a new rate filing, therefore there is no prior rate history.

Coordination of Benefits
All coordination of benefit savings has been reflected in the baseline starting claims cost.

Relation of Benefits to Premium
TABLE-9 details each specific component of the retention load. These expenses are based on anticipated needs of Colorado-specific business.

Lifetime Loss Ratio
The products included in this rate filing were not priced using a lifetime loss ratio standard.

Provision for Profit and Contingencies
The portion of the retention load for profit and contingencies is given in TABLE-8.

Premium Modalization Rules
Not Applicable

Claim Liability and Reserves
Incurred but not paid (IBNP) reserves which includes an amount for claim amounts reported but not yet paid will be established using a lag factor approach. This method uses claim payment histories to estimate the amount of claims that have been incurred in a particular time period. From the incurred amount, the actual paid amount is subtracted to get the IBNP reserve.

Active Life Reserves
Not Applicable, there are no active life reserves for this product.

Coinsurance Adjustment
Coinsurance amounts may be equal for benefits provided by participating providers, or they may differ depending on whether the member gets services from a participating or a non-participating provider. Additionally, coinsurance amounts may differ between Pediatric and Adult plans. To determine the coinsurance adjustment factors that apply to a given product option, refer to TABLE-1.

Deductible Adjustment
Deductibles, if present, are $50 per person per benefit year. Deductible factors are applied to Adult plan claim costs. The benefit year deductible can either apply to diagnostic and preventive services, or it can be waived for diagnostic and preventive services. Factors for the two deductible options are found in TABLE-2. Pediatric plans are subject to a $50 deductible on non-Class I services.

Annual Maximum Adjustment
The annual maximum for each person can be between $500 and $2,000 per benefit year. Adjustment factors are shown in TABLE-3. Pediatric benefits do not have an annual maximum amount on participating provider benefits and a $1,000 annual max on non-participating provider benefits which is reflective in the Pediatric starting claim costs.

Dependent Age Adjustment

Dependents are children of the individual. All product options assume that children of enrolled individuals are covered up to age 26, regardless if they are a student or not.

If the dependent child is under the age of 19, they will have a Pediatric EHB dental benefit plan design. If the dependent child is between the ages of 19 up to age 26, they will receive an Adult dental benefit plan design. Dependent coverage up to age 26 is assumed in the starting claims cost, so no claim factors are needed for this pricing assumption.

Geographic Area Adjustment

Anthem BCBS only markets to individuals who reside in the state of Colorado. This rating model does not use different geographic areas within Colorado, therefore the rates developed in this model are used for the entire state of Colorado. Given that rates apply to the entire state, one geographic area adjustment factor is used for all rates.

The Geographic Area Adjustment varies by rating area and is in TABLE-4.

Occupational Adjustment

An occupational adjustment factor is not used in this rating model.

Annual Trend

The starting claim costs were developed for an effective mid-point date of July 1st, 2012. The trend formula is $(1 + (\text{trend } \%/100))^{\wedge((\text{mid-point of rating period} - \text{July 1, 2012 expressed in integer half months})/24)}$.

Starting July 1st, 2012, claim costs are expected to increase at a trend of 5.00% annually in half-month increments. Premium rates will be guaranteed for 12 months, but for purposes of new sales, will change annually using the middle of the rating period to calculate the trend amount. For example, the January 1st, 2014 to December 31st, 2014 uses a rating period midpoint of June 30th, 2014 in calculating the trend amount.

Prior Coverage

These Anthem Dental products may have waiting periods for Class II and Class III services for Adult plans, as discussed below. In some circumstances, if the individual purchaser has had prior comparable coverage, waiting periods will be waived. However, prior coverage is not a pricing variable used in the pricing model. There is no waiting period for Pediatric EHB benefits.

Benefit waiting period factor

Certain Adult plans may have waiting periods before certain categories of services will be covered under the plan. These waiting periods can apply to basic services, major services. If applicable, the waiting period for basic services will be 6 months, and the waiting period for major services will be 12 months. For purposes of waiting periods, Endodontic, Periodontic, and Oral Surgery services are included in major services and have a 12 month waiting period. The Pediatric EHB benefit does not have any waiting periods on services other than dentally necessary orthodontia, which has a 12 month waiting period which is figured into the orthodontia starting claim cost. The appropriate adjustment for claims cost can be found in TABLE-5.

Reimbursement

The assumed level of provider reimbursement in the starting claims cost is set at the average of national dental submitted charges. The allowed reimbursement for the Anthem Dental Pediatric/Adult/Family products are the same whether or not the member sees a participating provider or a non-participating provider. The reimbursement adjustment factors for the Anthem Dental Pediatric/Adult/Family products are found in TABLE-6.

Orthodontia

Dentally necessary orthodontia is part of the Pediatric EHB benefit. When a non-participating provider is used, there is a $1,000 Lifetime Maximum benefit. There is no Lifetime Maximum benefit when a participating provider is used. Supplemental cosmetic child orthodontia is included for family purchasers that select the Anthem Dental Family Enhanced Plan for child dependents age 8 up to age 19.

Retention

Retention is a percentage of gross premiums and includes administrative expense, profit and risk charge, and premium tax as required. The retention table is shown in TABLE-9. The retention also includes provision for a writing agent commission as well as a commission override if applicable. The retention breakout differs between products sold On-Exchange and Off-Exchange, however the total retention is equivalent to achieve the same price as shown in TABLE-9.

Expected Loss Ratio

The expected loss ratio for this product is 70.54%.

Premium

The Anthem Dental Rating Worksheet (Exhibit 1) yields per member per month rates. The maximum number of child dependents that premiums would be collected for is three as determined by Exhibit 3. The premium for the Anthem Dental Family product is the sum of the individual premiums of the Pediatric and Adult benefits multiplied by the Family Factor.

Provider Usage Factor

The Anthem Dental Pediatric/Adult/Family products use the Anthem Prime network. Provider usage factors for the Anthem Dental Pediatric/Adult/Family products are shown in TABLE-7. The factor which applies to participating providers, and the inverse, which applies to non-participating providers, will be applied respectively to determine the Participating Provider premium and the Non-Participating premium in the Rating Worksheet. The final premium rate is then the sum of the premiums for the participating provider benefits and the non-participating provider benefits.

To the best of my knowledge, this rate filing is in compliance with applicable laws and regulations of the state of Colorado, and with the rules of the Department of Insurance. I certify that the rates are not excessive, inadequate or unfairly discriminatory. I also certify that the rates are reasonable in relation to the benefits provided. The actuarial methods, considerations and analysis used in forming my opinion conform to the relevant Actuarial Standards of Practice as promulgated from time to time by the Actuarial Standards Board, whose standards form the basis of this statement of opinion.

Robert L Mikkelsen — 6/12/13

Robert L. Mikkelsen, F.S.A., M.A.A.A.
Actuary

Date